The effect of social work intervention using the medium of play on the self-esteem of learning disabled children.

Josephine Helena. Wilds

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THE EFFECT OF SOCIAL WORK INTERVENTION USING THE MEDIUM OF PLAY ON THE SELF-ESTEEM OF LEARNING DISABLED CHILDREN

by

JOSEPHINE HELENA WILDS

A Thesis submitted to the Faculty of Graduate Studies through the School of Social Work in partial fulfillment of the requirements for the Degree of Master of Social Work at The University of Windsor

Windsor, Ontario, Canada

1983
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ABSTRACT

THE EFFECT OF SOCIAL WORK INTERVENTION USING THE MEDIUM OF PLAY ON THE SELF-ESTEEM OF LEARNING DISABLED CHILDREN

by

JOSEPHINE HELENA WILDS
ABSTRACT

The purpose of this study was to determine if social work intervention used in conjunction with remediation would increase the self-esteem of learning disabled children. The intervention consisted of a combination of non-directive and directive play therapy sessions held on a weekly basis over a period of twelve weeks. During this time, contact was maintained with the parents in order to answer their questions, offer support and obtain feedback regarding their observations of the children.

A sample of six children from a Learning Disabilities Class was used. The children were randomly assigned to a control or experimental group. In order to assess both the subjective and behavioral aspects of self-esteem, three data collection instruments were used:

1. The Coopersmith Self-Esteem Inventory
2. The Coopersmith Behavior Rating Form
3. Frequency recording of indicators of self esteem observed during the play sessions.

Both groups of children answered the self-esteem inventory pre and post intervention. The classroom teacher filled out the behavior rating form on all the children pre and post intervention. The researcher recorded the occurrence of specific behaviors during each of the sessions.
Although the scores of the experimental group increased to a greater degree than those of the control group, statistical significance was not attained, partly due to the small sample size.

Positive behavioral and attitudinal changes were observed in the play sessions. According to teacher and parent reports these changes were carried over to other aspects of the children's lives.

The fact that these changes occurred within a period of only twelve weeks suggests that social work intervention using the medium of play is a promising means of helping learning disabled children accept and value themselves. Further research is required to validate the use of play therapy as an effective form of intervention with learning disabled children.
ACKNOWLEDGEMENTS

I wish to express thanks to the Research Committee for their counsel and support. Dr. Bud Hansen's blend of optimism and pragmatism was much appreciated and helped me to maintain a balanced perspective throughout the project. Dr. Kumar Chaterjee's suggestions helped to clarify content particularly in the areas of description of intervention and recommendations. Dr. Wilf Innerd's enthusiasm and expertise in the areas of play and child development were appreciated. His suggestions helped provide continuity, particularly in the literature review.

Thanks are also extended to the School Board for their permission to conduct this research project, as well as to the principal and classroom teacher for their interest and co-operation. The children who participated in the study deserve recognition and gratitude for the vital role they played. They reinforced my belief in the strength of the human spirit.

A very special thank you is sent to my family whose love and encouragement made all the difference.
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CHAPTER 1

THE CHILD WITH A LEARNING DISABILITY

In the past twenty years there has been an upsurge of interest in learning problems. Learning is a complex process that involves every aspect of a child's being. According to social psychologists, an individual's conception of himself is learned from social interaction. To a large extent the responses of others to him determine how he sees himself.

Studies have indicated that the learning disabled child is more likely than a non-disabled child to have a negative self-esteem. The child who has difficulty learning often identifies himself as a failure and gets caught in a self-defeating cycle of failure. In an effort to break this cycle and redeem his self-esteem the child may act out or withdraw, further alienating himself from his environment.

It is now recognized that learning disabilities in children are far more common than was suspected even a few years ago. Although estimates of the prevalence of children with learning disabilities vary widely, from 1 per cent to 30 per cent of the school population the actual number is uncertain. Lerner (1981) states "there are likely to be at least several children in every classroom who can be
identified as learning disabled." (p. 17)

As many as fifty per cent of children in elementary schools referred to school counsellors for behavior problems have specific identifiable learning disorders (Whittaker, 1975).

This study developed as an outgrowth of the researcher's interest in a holistic approach to social work intervention with children. The interdependence of cognitive skills, affective functioning and social skills is well recognized. The problem facing the practitioner is how to touch on all these aspects during intervention.

An additional factor that merited consideration was that many of the children being seen were diagnosed as having learning disabilities. Although presenting symptoms varied, the common theme for all the children was a low sense of self-worth. Since self-esteem is the foundation upon which future growth and development is built, this was chosen to be the main focus of this study.

Social work intervention using the medium of play in conjunction with remediation was seen as providing an opportunity for the child to recognize and utilize his strengths and thus to increase his self-esteem.

Social work intervention was seen potentially as providing:

1) A method of treatment for the child who is demonstrating behavior problems.
2) A preventive approach by helping the child accept and value himself so he need not seek dysfunctional means of meeting his self-esteem needs.

3) A means of enhancing the child's self-esteem.

4) An opportunity for parents and teachers to be further involved in helping the child develop a positive self-esteem.

A sample of six children from a special learning disabilities class was randomly divided into an experimental and control group. Three measures of self-esteem were used in an attempt to obtain an accurate indication of the children's self attitudes, pre and post intervention.

Intervention consisted of a minimum of ten individual play session for a period of 45 minutes on a weekly basis over a period of twelve weeks. Individual rather than group sessions were chosen because one to one contact often makes it easier for the child to express his feelings. Play therapy can build a child's sense of confidence in himself. A combination of structured (Lieberman, 1979) and non structured (Axline, 1969; Moustakas, 1959) models of play therapy was used.

Written consent of the parents was obtained prior to beginning the study. Contact was maintained with the parents of the experimental group during the twelve week period of intervention.

This study evaluates the effect of social work inter-
vention using the medium of play on the self-esteem of learning disabled children. Social work intervention with a focus on increasing self-esteem is seen as one way of helping the learning disabled child direct his emotional energy toward positive growth rather than defensive behavior.

The following sections contain:

1) A review of the literature dealing with self-esteem, learning disabilities and their effect on child and family, play as a form of social work intervention and the role of the social worker in the treatment of the learning disabled child.

2) A description of the research design and methods used to evaluate the intervention. A detailed description of the social work intervention that was used.

3) An analysis and discussion of the research findings.

4) A summary of the study together with conclusions drawn from the research findings and recommendations for future research, social work practice, as well as for educators and families of learning disabled children.
CHAPTER II

REVIEW OF THE LITERATURE

The plan of this literature review is to describe the concepts and issues upon which this study is based. The following areas will be discussed:

1. Self-esteem
2. The middle years of childhood
3. Learning disabilities
4. The self-esteem of the learning disabled child
5. The family as a system
6. Play
7. The role of the social worker in a multidisciplinary setting

A learning disability is seen as a multi-faceted problem which affects every aspect of the child's life. In this review emphasis has been placed on the affective needs of the child particularly in the area of self-esteem.

The value an individual places on himself has a powerful influence over his perception of his environment and his behavior. Self-concept theory and the development of self-esteem will be explained in order to acquaint the reader with the present status of self-esteem research and ideas.

An overview of learning disabilities will be given
beginning with a brief historical perspective, followed by a description of the current state of learning disabilities and a look at emerging directions.

The learning disabled child who meets frustration and failure in trying to understand his environment often emerges with feelings of inferiority. The relationship between learning disabilities and self-esteem will be examined.

Family involvement is a vital component in the treatment of the learning disabled child. Attitudes and expectations of parents and siblings reflect in the child's feelings about himself. For this reason, consideration will be given to the topic of the family as a system.

The concept of play as a therapeutic tool will be described along with its particular relevance to the learning disabled child.

In conclusion, attention will be focused on the role of the social worker as a member of the multi disciplinary team.

1. **Self-Esteem**

Self-Esteem is defined as the individual's evaluation of himself. It expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant or worthy, i.e. "It is a personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself."
(Coopersmith, 1967, p.5.) It is a subjective experience which the individual reveals through his behavior.

Individuals are not born with a ready made self image. The actual development of self-esteem is a learned process. The child develops his self image from the reflections of himself that he receives from significant others in his environment. "The shape and quality of the self reflect the images of important people in the growing child's life." (Mead, 1934, p.13)

Sullivan (1953) accepts Mead's formulation of the origins of self-esteem and agrees that the self-concept of the individual is in many ways a reflection of the appraisals of others. (Sullivan, 1953, p.118)

Erikson (1959) also adopts an interactional frame of reference in which all the elements of a situation are considered as interacting with one another to produce the current reality. His orientation is that the individual’s mastery of his life task is dependent on the significant others in his environment. In order to grow and develop, children need to be cared for and nurtured by other human beings.

Although Roger's humanistic approach (1951) does not directly address the development of self-esteem, the synthesis of his self theory with Sullivan's interpersonal theory does contribute to the understanding of this topic. He agrees that the child internalizes the values placed
on him by others.

As the child's experience broadens, new criteria for his self worth are introduced. New role models, feedback agents and evaluators are met. Increased independence results in a greater emphasis on the self with a subsequent shift to self evaluation of behavior. It is important to remember that the child's inner repertoire of criteria for deciding self worth is derived primarily from his parent's opinion of him. Gardner, (1973) underscores this point when he states, "So deep and lasting is this earlier reflected appraisal, that a child whose parents despise him may never be able to gain a full feeling of self worth." (p. 55)

Coopersmith (1967) identifies four major contributing factors to the development of self-esteem:
1) acceptance from significant others
2) history of successes
3) personal goals and values
4) defenses and controls (p. 38-43)

More recently, Felker (1974) incorporated Coopersmith's ideas and describes the process of the growth of self-esteem. If development lags in any of these areas an important part of self esteem will be missing. "Self-esteem is the result of the development of a sense of or a feeling of belonging, competence and worth." (p. 25)

Studies done by Coopersmith (1969) indicate that "at
some time preceding middle childhood the individual arrives at a general appraisal of his worth, which remains relatively stable and enduring over a period of several years." (p.5)

The child who believes himself to be "bad" or "stupid" is generally not willing to accept evidence that he is indeed better than he has decided himself to be and may persistently act in such a way as to verify his assumptions. Carl Rogers (1959), asserts "Behavior is largely consistent with the concept of the self." (p.158). The individual whose behavior is discrepant with his self concept is "incongruent" and subsequently vulnerable to anxiety.

Although self-esteem is formed in the early years and is relatively resistant to change (Coopersmith, 1967) modifications can be made to alter distortions that were formed from early experiences. "Self-esteem is not forged for all time, although once established, it is not easily disturbed." (Briggs, 1970, p. 37)

Rogers (1961) emphasizes that every person has an innate tendency to develop to his fullest potential in a positive direction. Since self-esteem is learned, it can be unlearned and something new can be learned in its place. (Satir, 1972, p. 22-30)

Prior Research On Self-Esteem

Ruth Wylie (1974, 1968, 1961) in her review of research literature in the area of the phenomenal self reports
that "...one finds a bewildering array of hypotheses, measuring instruments and research designs." (Wylie, 1961, p. 3). Consequently, the results cannot be simply synthesized. She identifies several problem areas of measuring self-reffrant constructs:

1) the terms used are not operationally defined and are therefore intertwined and overlapping

2) there is a lack of information on the construct validity and reliability of measurement instruments

3) There is a lack of systematic scaling techniques in constructing measurement instruments.

Coopersmith (1969) describes a method of determining self-esteem based upon a combination of the subject's response to a self-esteem inventory and a rating of his behaviors which are related to self-esteem. High test-retest reliability was found for both instruments.

Research on the effects of therapy on self concept has a great deal of practical value in improving clinical practice but at the same time it contains several inherent as well as several avoidable limitations. The lack of definitive results is identified by Wylie as due to:

1) lack of control groups
2) indirect relevance to the topic of therapy and self concept
3) validity and scaling problems
4) lack of definition of criteria indicating improvement.

(Wylie, 1969)
Recognizing the limitations of self report as an assessment technique, Samuels (1977) recommends using self concept inferred from behavior as a better method of evaluating children's self feelings.

Researchers have attempted to measure specific processes that affect self concept. Coopersmith's intensive study of self-esteem (1959-1965) focuses on the antecedent conditions that contribute to the development of positive and negative attitudes toward oneself. Several researchers have observed a positive correlation between self concept and achievement. Children with learning disabilities tend to perceive themselves less adequately than those who are achieving academically. (Coopersmith, 1959; Purkey, 1970; Sears, 1970; Felker, 1972.)

2. The Middle Years of Childhood and Entry Into School

Lieberman (1979) defines the middle years as being "between the ages of 6 and 12." (p.32) These years are marked by a growth of physical and intellectual abilities. During this period as their environment expands, children increasingly define their person from reflections outside the immediate family. (Briggs, 1970, p. 138-148). They differentiate between the egocentric world of childhood and the broader world of society.

Erikson (1953) describes the middle years as being directed toward establishing mastery and autonomy. Peer acceptance combined with mastery of physical, academic and
social skills contribute to the formation of a positive self-esteem. The world becomes more comprehensible as primary process thinking is replaced by stabilized and logical thought.

One of the major factors contributing to the child's growth in independence is his entry into school. Teachers and peers become alternate models and alternate sources of rewards and punishment.

The school situation adds stress to the child's life. Felker (1974) states "the pressure of school and the resulting anxiety are partly due to the fact that the child is thrust into a situation which is highly evaluative and over which he exercises very little control." (p.67). The goals of education are set by society and the teacher as the representative of society follows a set of objectives designed to achieve these goals.

Children naturally tend to do those things they can do well. In school the situation is changed. Many children have difficulty gaining competence in certain academic areas but they are still required to work at the task. (Gardner, 1973, p. 54-60).

Children who have difficulty mastering the tasks required in school are likely to develop negative evaluations of self. "If the child experiences no satisfaction, asking him to continue the activity is like asking him to bang his head against the wall." (Felker, 1974, p. 62).
3. Learning Disabilities

Although learning disabilities are generally defined in educational terms, it must be recognized that the disabilities are manifested in the child as a whole. Learning contains cognitive and affective as well as overt behavioral aspects. Negative expectations, self-defeating thoughts, anxiety and fear of failure may interfere with learning and social functioning.

The field of learning disabilities is relatively young. Although the symptoms of learning disabilities were not unknown in children, they were ignored by medical and educational specialists. (Schapiro, 1979)

The astounding growth of interest in learning disabilities in the past twenty years by professionals from diverse backgrounds has led to a certain amount of confusion. A prime example of this confusion is seen in the number of terms used to define learning disabilities; i.e., minimal brain dysfunction, perceptual disability, specific learning disability, educational handicap, underachievement, etc. (Hallahan, 1976, p. 4)

The issue of whether or not children with learning disabilities have suffered brain injury is a hotly debated one. The earliest work in learning disabilities was done with children who were brain injured. (Strauss & Lehtinen, 1947). The term Minimal Brain Dysfunction came into use when it was recognized that children of normal intelligence
exhibited behavior similar to that of brain damaged children. Hallahan (1976) cautions practitioners to be wary of making an "inferential leap" from the behavior of a child to brain damage as the cause of the behavior.

The term "brain injured" generated much ambiguity and conflict in educational and parent groups and in 1963 a conference was sponsored by a group of parents to examine the problems of the perceptually handicapped and to come up with a term to describe these children.

The term "learning disabilities" was agreed upon to describe children who have disorders in development in language, speech, reading and associated communication skills needed for social interaction. Children who have sensory handicaps or are mentally retarded are excluded from this classification. (Kirk & McCarthy, 1975)

Some researchers in the field of neurophysiology are working in the area of medical computer science to detect signs of brain dysfunction that could not be previously identified by E.E.G. or Brain Scan. By locating the exact areas and types of dysfunction in the brain, they claim that more precise treatment can be implemented. (Smith, 1979, p. 27). Rourke (1981) asserts that "there is sufficient evidence of central dysfunctioning, that its presence or absence can no longer be considered a matter of conjecture." (p. 26)
In direct opposition to this stance is the psychoanalytic theory that argues that most learning disorders are functional and that long term learning difficulties require extensive psychological intervention. (Hammer, 1967; Bettelheim, 1982).

Where there is no known cause, many causes are hypothesized. Batemen (1973) cautions that "...the utility of truth, in this instance, is dependent on the professional orientation of the observer," (p. 675).

Kirk (1975) takes issue with the preoccupation with labelling or classifying these children into categories and advocates observation of their behavior and a formulation of a treatment plan based on a behavioral and psychological assessment. (p.40)

Conversely, others argue that a label is useful in providing a frame of reference for professionals working with these children and is necessary for conducting meaningful research. (Silverman & O'Bryan, 1973). This issue continues unresolved.

The prevalence and seriousness of learning disabilities together with the lack of specificity around causes has led to the emergence of a variety of teaching methods and materials. Yet "...the efficacy of these methodologies has not been proved under rigorous evaluation and research." (Silverman & O'Bryan, 1973, p. 3).

Silverman and O'Bryan (1973) describe a research project
designed to test assumptions underlying perceptual and motor training programs. They conclude that perceptual motor training as a remedial approach to improve reading is questionable as far as success and they suggest that "a pleasant, reinforcing play activity program appears to be at least equally effective." (p.9). Unfortunately the authors do not examine the possible reasons behind this finding; i.e., what factors in the play experience make it a positive influence?

Bateman (1975) contends that the emphasis must shift from diagnosis and remediation to prevention. This can be done by designing teaching programs that present the material to be learned in a simple, direct manner. She describes the Engelmann-Becker (E-B) Follow Through model to teach academic skills quickly and efficiently. She states "it is not necessary to make a special effort to raise the self esteem of the children,...high self-esteem will be a by product of competence." (p.21). However, Bateman fails to acknowledge that the E-B model relies heavily on the use of self-esteem enhancing techniques; e.g., positive reinforcement is a key element of the program; tasks are structured so that success is ensured; constant feedback is given. The E-B model appears to be an example of an integrated affective/cognitive curriculum that recognizes the influence that self-esteem has on academic achievement.

Since the learning process is so complex and there are
so many possible influences, any approach to the study and treatment of learning problems must encompass several factors. All aspects of the child must be considered when assessing academic difficulty.

What seems to be needed is a unified multidisciplinary approach to the problem of learning disabilities - "a co-ordinated effort with each field contributing its expertise to the analysis and treatment of the child." (Lerner, 1981, p.6)

4. The Self-Esteem of the Learning Disabled Child

Learning disabilities affect both cognitive and social functioning. In our success oriented society the child who is unable to learn is often considered a failure. He in turn begins to see himself as a failure. The child who identifies himself as a failure cannot learn - and a self-defeating cycle is created.


This finding is not surprising since one of the major elements described as fundamental to the formation of a high sense of self-esteem is the development of a sense of competence. The child who is not achieving mastery of academic skills may compare himself to his peers and find himself
deficient. Children tend to view their personal worth and adequacy in part by the adequacy of their school performance. (Black, 1974)

A child who has learning difficulties is frequently one who fails repeatedly, regardless of effort expended. The child feels 'dumb' because of an inability to do what others can do and often because other children reinforce the child's negative opinion of self. (Dow, 1981, p. 18)

The problem of low self-esteem is described as "universal" in children with learning disabilities. (Gardner, 1973, p. 54).

Although the manner in which low self-esteem is manifested is varied, the underlying motivation is the same—an attempt to compensate for real or imagined deficiencies. Those who experience frequent frustrations and failures may develop a range of reactions to deal with the stress, such as fear or withdrawal reactions, somatic complaints, excessive anxiety, depression, or aggressive tendencies. (Gitterman, 1979, p. 218).

Thomson and Hartley (1980) observed that frequently children with learning disabilities react to their difficulties either by withdrawing emotionally or becoming aggressive. He sees this as a means of compensating by obtaining negative attention from others.

The "clowning" reaction has been describes as a commonploy of the learning disabled child, used to divert attention from feelings of academic or social inadequacy. (Gitterman, 1979. Gardner, 1973). The child who meets failure
impatience and ridicule in a world he is trying to comprehend may begin to see himself as stupid, bad or lazy and may become afraid to risk himself in trying to learn.

A study done by Bryan and Pearl (1981) reveals that learning disabled children "tend to attribute their failures to themselves and their successes to external causes." These maladaptive beliefs are likely to lead to an attitude of learned helplessness that could hamper attitude and motivation even in areas that are not affected by the specific learning difficulty.

Bryan and Pearl further state that parents and teachers may also fall victim to learned helplessness as a reciprocal reaction to the learning disabled child. The implications of this finding are critical. These low expectations could lead to a reinforcement of negative self concept for the child. In addition, if educators and parents think they cannot help the learning disabled child, "...it is unlikely that they will expend the effort to do so ..." (Bryan & Pearl, 1981, p. 95) This will further contribute to the cycle of failure.

The learning disabled child has been identified as a child at risk for academic failure, anti-social behavior and psychopathology. (Gitterman, 1979; Resnick, 1980).

Literature dealing with the affective needs of the learning disabled child suggests that attention to the development of positive self esteem should be an integral part
of intervention. While this is but one small area, it is the cornerstone upon which growth and development is built.

The frustration and failures attendant upon being disabled often create such severe feelings of inferiority as to render the child relatively unresponsive to a strictly remedial approach. Thus, the child needs concurrent help with his feelings resulting from the learning deficiency. (West, 1978, p. 57)

5. The Family System

The family is a system consisting of "two or more units relating to each other in such a way that if there is a change in one, it affects the other and the reaction of the second in turn affects the first." (Scherz, 1970, p. 22)

Each family develops rules, conscious and unconscious, to meet the needs of its members and to maintain a state of balance within the family. "The disturbed family has learned to accommodate and adapt to such behavior as hyperactivity and acting out so that this has become a way of life for the group." (Furgeri, 1976, p. 26) Because some of these rules are unconscious, the family members are unaware of the emergent patterns of interaction. These patterns need to be understood if a correct assessment and intervention method is to be developed. For this reason, direct observation of family relationships is helpful. (Scherz, 1970; Satir, 1972)

Since the family system is also a part of a larger system (society), its social and physical environment must be considered both in the assessment and intervention phase. (Germain & Gitterman, 1980, p. 13)
Anderson (1980, p. 14-15) describes the "tyrannical child syndrome" which she claims is often found in association with the diagnosis of specific learning disability. The pattern is characterized by the family continually giving in to the child's demands with the result that the child gains an unrealistic sense of omnipotence that serves to further inhibit his/her cognitive and psychosocial development.

Learning disabilities affect the entire family as well as the individual child. The family typically reacts to a diagnosis of Learning Disability with a variety of emotions - shock, denial, anger, guilt, shame and disappointment. (Kronick, 1981, p. 39). Practical demands of time and energy must also be considered. "Anxiety, pain and frustration become ways of life and it is not surprising that parents tend to follow the line of least resistance to save themselves." (Anderson, 1980, p. 15).

Prior to this, Whittaker (1976) acknowledged the heightened stress faced by the family and observed that at least some of the "pathological" family behavior is reactive to the child's disturbance. However, he sees this as a potential hazard that may cause the social worker to "...grossly underutilize the most valuable natural resource in child treatment: the parents themselves." (p. 44)

Counselling is essential to help parents deal with negative feelings about themselves and their child and to
cope with problems in family functioning that are inherent in this situation.

A treatment model integrating family systems and learning problems is described as contributing to the easing of family tensions and the improvement of the learning disabled child's performance in school. (Haufrecht & Mitchell, 1978)

Briard (1976) emphasizes the importance of enlisting parents as allies in the overall treatment of the Learning Disabled Child. He describes three levels of approaches to treatment. 1) parent involvement

2) psychotherapy to help the child deal with secondary emotional problems

3) special education to remediate the learning disability. (p. 583)

Parents must be convinced of the effectiveness of the program. Honest discussion with parents about the child's problems can not only ease family tensions but helps protect the school-family relationships from "... potential acting out the displacement of the parent's disappointment, ambivalence and frustration." (Gilboy, 1981, p. 58)

Recognizing and dealing with the family's defensive feelings frees them and allow them to direct their energy toward positive family growth. "Children who receive the support of a warm, understanding and supportive family are more likely to compensate better for their disability and become socially comfortable, independent, happy adults than those who don't have such support." (Kronick, 1981, p. 40)
6. **Play**

Wolfgang, Mackender and Wolfgang, (1981) define play as "an activity engaged in for the purpose of enjoyment." (p. 4) They state that play helps children understand and master their feelings and to practice and master new intellectual, social and physical skills.

Caplan & Caplan (1973) describe the extraordinary power of play "... it can help to strengthen personality, encourage interpersonal relations, further creativity and the joy of living, and advance learning." (p. 11)

The importance of play in understanding and educating the child was recognized at least as far back as Rousseau, however, the use of play in therapy was first recorded by Sigmund Freud. (Lebo, 1958). Since that time, a variety of active and passive forms of play therapy have evolved.

Play therapy based on the fact that play is a natural part of a child's life and development provides the child with a natural means of approach to the therapist. Through play, children can express hidden wishes and fears which they are unable to communicate verbally. (Lieberman, 1979, p. 287)

As a child plays, insight learning and identification each appear, leading to a sense of mastery of the inner and outer world. (Piers, 1973, p. 624) Play therapy may be directive; i.e., the therapist assumes he is more aware of the needs of the client than the client is and therefore controls
the direction of the therapy. He takes the major responsibility for the therapeutic experience. (James, 1977, p. 9)

The non-directive approach to play therapy emphasizes that the answer lies within the client.

Axline (1969) and Moustakas (1959) advocate a non-structured approach. Axline's basic premise is that the child has within him, the power to change and grow. This power will be realized "only when the conditions are such that his emotional energies are not being used in anxiety and fear." (p. 14) The role of the therapist is to provide the conditions conducive to self awareness and growth.

Moustakas (1959) sees the relationship between the child and the therapist as providing the impetus for growth. The therapist participates by "being with" the child. The therapist does not interpret or suggest, but takes his lead from the child. The basic attitudes which are conveyed by the therapist are acceptance, faith and respect and according to Moustakas, it is within this type of environment that the child's capacity for self growth will flourish.

Differences of opinion exist as to which form is the most appropriate therapeutic tool. Not surprisingly, these differences seem to be based on the theoretical orientation of the various authors. On the other hand, Hambridge (1955) reports that many therapists who work with children have incorporated a mixture of structured and non-structured approaches. (p. 607)
Brenda Burns (1970) outlines seven ways that play can be used in social work intervention:

1) Play may be used for ventilation. Children may express their pent up emotions through their play with a subsequent release of tension.

2) Play can be used to bind anxiety. It can be used as a secondary activity which reduces the child's anxiety level, enabling him to talk about feelings and events that are upsetting to him.

3) Play can be used for communication. Through his play, a child lets the therapist know how aware he is of his problem. This provides a clue for the therapist as to how directly she can approach dealing with the problems. The therapist aims to respond to the child's communication in such a way that "the child understands what is taking place and can make use of the experience after he has left the office." (p. 40)

4) Play can be used in the service of regression. Some children need to work through earlier unresolved developmental stages in order to proceed with growth. This can be done through the type of play and the materials chosen by the child.

5) Play can be used for the development of skills. The mere fact that he can learn a skill may enhance a child's self esteem.
6) Play can be used to help modify a life style. The process of play reveals how a child is in his real world. The therapist can make a child aware of a self-defeating approach to life and help him make changes.

7) Play can be used for "working through". Burns identifies this as an extremely important function of play. "A child can use play to work through the basic conscious and unconscious struggles and conflicts that brought him into treatment." (p. 38) Through play a child can face his feelings and learn to control them. (p. 37-41)

Play can be used in different ways and with different goals. Social workers must draw on their knowledge and expertise in order to discern when and how to use play in the most therapeutic way for their clients.

Learning disabled children face failure as they struggle to keep up with their peers academically and often socially. Consequently, their self esteem is low. The medium of play provides a means through which they can learn to accept and value themselves.

Landreth (1969) suggests a multidisciplinary approach to the treatment of learning disabilities, incorporating the use of play therapy in conjunction with the methods of remediation. The play therapy described by Landreth is within the frame of reference of non-directive therapy. It is described as providing children with an environment in which they learn to value themselves and to devote their energy to positive psychological growth rather than to de-
fensive behavior.

Siegel (1970) investigated the effectiveness of play therapy with other modalities in the treatment of children with learning disabilities. Primary interventions were educational (special class, tutoring). Secondary interventions included play therapy, parent counselling or a combination of the two.

In comparing the effectiveness of the secondary intervention, it was found by Siegel that therapist involvement was the critical variable. Whether the therapy was directed toward the child, the parent, or both, significant improvement was found when this group was compared to a group who did not receive counselling. Unfortunately, the criteria upon which improvement was measured was not stated.

Gitterman (1979) describes a preventive approach to intervention with learning disabled children and their parents. Groups of four to six children were formed and met weekly for twelve sessions. A format that included time for both play and talk was used with elementary school age children. The parents also met in a group for the purpose of increasing their understanding of learning disabilities, expressing their concerns and obtaining support. (p. 217-226) The program was described as successful, although specific measurement tools were not identified as being used in evaluation.

A study done by DuPlessis and Lochner (1981) considers
the effects of group psychotherapy (combining structured and non-directive models) on the emotional development and socialization of four 12-year-old boys with learning disabilities. The researchers found that the addition of therapy to the general remedial program, enhanced the progress made in the social, emotional and scholastic fields.

Fleming and Snyder (1947) determined that measurable changes in the area of personal feelings toward self occurred as a result of a twelve week session of non directive group play therapy using a sample of 7 children.

Axline (1949) reported on the effectiveness of play therapy in helping poor readers. At the end of three months, twenty-five of thirty seven second graders identified as poor readers gained in reading ability.

Prior Research on Play Therapy

Although play is recognized as a valuable method of intervention, the existing body of theory and research on this topic is meager and scattered. Because of the lack of definitive research on the effects of play there remain educators and therapists who relegate play to the lower end of the value scale (Caplan & Caplan 1973).

Further developments in play therapy are dependent upon the adoption of a suitable theory. "Without such a theoretical framework, play therapy may be in danger of becoming immeshed in the regularity of its process until ... it becomes process bound and unproductive." (Lebo, 1958)
James (1977) concurs that it is difficult to apply or draw conclusions from available material in the area of play therapy because much of it is outdated and not tied concretely to a theoretical framework.

Research procedures in the area of play are in the infant stage ... this lack of research data points to the fact that new techniques and models for research need to be developed which will be sensitive enough to evaluate process, outcome and follow up in the field of play therapy. (p. 190)

7. A Multidisciplinary Approach to Treatment: The Role of the Social Worker

It is recognized in the literature that the effects of learning disabilities are demonstrated well beyond the child's academic sphere. Therefore, a simple, single approach to treatment is not realistic.

To treat a child in a holistic manner requires a multidisciplinary approach. This approach is fraught with potential dangers, the most obvious being a fragmented treatment plan resulting in a feeling of confusion for the involved child and his family, as well as for the social worker. The key is to make the best use of specialized personnel by enabling them to function within their particular area of expertise. (Lieberman, 1980) The benefits of parent-teacher-social worker collaboration in terms of fostering the child's psychological development (encompassing affective, social and cognitive processes) have been demonstrated. (DuFlesis & Lochner, 1981; Gitterman, 1979; Haufrecht & Mitchell, 1978; West, 1978; Landreth, 1969)
The intermingling of the cognitive and affective areas must be stressed because of the important relationship between school success and the development of a positive self concept. This is not meant to deprecate the importance of the acquisition of skills in such areas as language, arts and arithmetic, but to attempt to achieve a balance between the domains. (Rogers, 1977, p. 78)

Social work education with its emphasis on the systems approach to problem solving prepares the social worker to assume the role of coordinating agent. Increased social work involvement within the educational system could serve to integrate the various professional services in order to effect an understanding of the whole child.

In addition, the individual support given to the learning disabled child could help build feelings of self esteem, increased confidence and improved learning ability.

Summary

The development of self-esteem is a learned process. The young child initially adopts a view of himself that is reflected from his significant caretakers. As his environment expands, teachers and peers become additional role models, feedback agents and evaluators. Eventually there is a shift to a greater emphasis on self evaluation of behavior. Learning disabilities often affect a child emotionally and socially as well as academically. The child may generalize his learning difficulties to other aspects of his being and may begin to identify himself as a failure. Family support and understanding is particularly important
to the learning disabled child as he attempts to compensate for his disability. Social work intervention using the medium of play with the child, together with collaboration with parents and teachers is seen as one way of meeting the child's affective needs.
CHAPTER III

METHODOLOGY

This chapter will be divided into two major sections. The first section will describe the research design and the methods used to evaluate the effect of social work intervention on the self esteem of the learning disabled child. Specific topics that are discussed include: the hypothesis, classification of the study, method of data collection, description of the instruments, basic assumptions, operational definitions, description of the sample and limitations of the study. The second section will contain a general and specific description of the intervention.

Research Question

Is there a correlation between social work intervention used as an adjunct to remediation and increased self-esteem in the learning disabled child?

Hypothesis

Social work intervention used as a complement to remediation will increase the self-esteem of the learning disabled child.

Null Hypothesis

Social work intervention used as a complement to remediation will not affect or will decrease the self-esteem
of the learning disabled child.

Classification of the Study

According to Tripodi's (1981) classification the research design used in the study is a classical experimental one also known as the pretest-posttest control group design. This type of design is expected to generate cause-effect knowledge.

Wechsler, Dobbin and Donald (1976) identify two major factors that determine the appropriate type of design to be used in a study:

1) the present level of knowledge about the subject to be studied.

2) the degree to which the findings are to be generalized.

A profusion of literature exists, describing self theory, learning disabilities and the benefits of play. The importance of the affective needs of the learning disabled child are well recognized. However, few empirical studies investigating the means of meeting these needs have been conducted. The need for research studies linking these three theories is clearly evident and the existing literature provides a sound foundation upon which more rigorous experimentation can be based.

Tripodi (1981) describes the criteria that must be met within the classical experimental design.
Internal and validity factors are controlled. It involves the manipulation of the independent variable by introducing it only to an experimental group. The control group receives no independent variable. Pretest and posttest measurements of the dependent variable are taken for both groups. Random assignment to the experimental and control groups is mandatory. (p. 220)

The classical experimental design is expected to generate cause-effect knowledge. This knowledge specifies that changes in the independent variable are responsible for changes in the dependent variable. Cause-effect knowledge "contributes to the development, refutation and expansion of theories about social work phenomena". (Tripodi, 1981, p. 202)

**Method of Data Collection**

An explanatory letter along with a consent form was sent to the parents of each child. (See Appendix A). After receiving parental consent, the researcher was introduced to the class and described the study to them. (See Appendix B). Having the teacher introduce the researcher and remain in the classroom during the description helped allay the anxiety the children might have felt about the study. This preparation was done one week prior to the beginning intervention.

The questionnaire was administered to all the children prior to intervention by their classroom teacher. She explained that the questions were not a test and that there are no right or wrong answers. She stressed the important
role the children played in the study and explained that the answers would not be seen by their parents or peers.

Hot chocolate was available to the children in a further attempt to help them to feel at ease.

The classroom teacher answered the Behavior Rating Form prior to administering the questionnaire to the children. The researcher met with the experimental group of children individually to explain the nature of the sessions and to schedule a meeting time.

Intervention in the form of individual sessions with the child as well as limited contact with the parents was offered over a period of twelve weeks. Each child was seen for a minimum of ten, 45 minute sessions.

Within one week of termination, the teacher again completed a behavior rating form on each of the children and administered the Coopersmith Self Esteem Inventory to them.

Data Collection Instruments

In order to measure self esteem in both its subjective and behavioral expression, three instruments were used to collect data:

1) the Coopersmith Self-Esteem Inventory (S.E.I.)
2) the Coopersmith Behavior Rating Form (B.R.F.)
3) observation of certain behaviors indicative of self esteem.
Coopersmith Self-Esteem Inventory (See Appendix C)

Although a broad range of instruments measuring various aspects of the phenomenal self was found, very few instruments could be found to measure the self-esteem of the latency age child.

The S.E.I. consists of 58 items based upon the Rogers and Dymond scale. The statements were rephrased so they could be used appropriately with this age group. (Coopersmith, 1967, p. 10). The items are concerned with the subjects' self attitudes in four areas: peers, parents, school and personal interest. The items were divided into two groups by agreement among five psychologists that they indicate high or low self-esteem.

The S E I. questionnaire was scored according to Coopersmith's system. Fifty of the items were designed to measure self-esteem, and eight items measured a defensive lie reaction. A maximum score of fifty was possible for general self esteem, which Coopersmith multiplied by two for convenience; a maximum score of eight was possible for the defensive lie reaction. The total score was obtained by dividing the general self-esteem score by the lie scores.

Test-retest reliability with a sample of 30 fifth graders after a five week interval was .88. Significant relationships of .36 were obtained with Iowa Achievement Test Scores and .29 with a sociometric rating (Coopersmith, 1959, p. 172).
Coopersmith Behavior Rating Form (See Appendix D)

In an effort to compensate for the problems of defensiveness and response set which are inherent in the study of subjective states, the child's self-esteem as it is manifested in his behavior was reported by his teacher. The BRF is a 13 item, five point scale on behaviors presumed to be related to self esteem. The behaviors to be used were selected after a series of observations of child behavior in and out of the classroom, interviews with teachers, principals and a clinical psychologist, as well as evaluations and discussions with a research committee.

"On theoretical and empirical grounds, the behaviors were assumed to be an external manifestation of the person's prevailing self appraisal." (Coopersmith, 1967, p.11)

The B.R.F. was scored by following a five-point rating scale for rating behavior and defensiveness. The total score was obtained by summing the behavior questions, multiplying by two and dividing this number by the score obtained on the defensiveness questions. The highest possible score is 33.3.

The test-retest reliability with a sample of 28 children after an interval of eight weeks was .96 (Coopersmith, 1967, p. 11)

Coopersmith reports substantial agreement between the S.E.I. and B.R.F. scores although he does not validate this with interpretable statistical information.
Indicators of Self-Esteem

The following behaviors were chosen as indicators of self-esteem based on Coopersmith's behavior rating form (1969) and Samuels' (1977, p. 182) description of generalized self concept indicators:

1. makes negative statements about self
2. engages therapist in play or conversation
3. seeks approval

Turkey and Cage (1973) developed "the Florida Key" to allow teachers to infer self concept. Using a sample of 1000 elementary school children they identified four factors to account for 92% of the common variance in self concept.

1. Relating
2. Asserting
3. Investing
4. Coping

These factors, along with the behaviors indicated in the SRF formed the base from which the above behaviors were selected.

Frequency recording was selected as the technique of recording each occurrence of the target behaviors during the intervention sessions. Frequency data is a measure indicating the total number of times the behavior occurs during a specified time span.

To ensure reliability each session was audio taped, enabling the researcher to accurately record each occurrence.
As the child's self esteem increases, behavior 2 should increase and behaviors 1 and 3 should decrease. The observational code is simple and clearly defined so frequency recording is easily implemented. Frequency recording is "appropriate for high or low frequency behaviors where the social worker is interested in how often the behavior occurs." (Grinnell, 1981, p. 385)

**Behavior Observation Code**

**Operational Definitions of Behaviors**

1. Makes negative statements about self—the child is critical of himself, his work products, his school work, grades, activities. He indicates he is not doing as well as expected e.g. "I don't draw very well."

2. Engages therapist in play or conversation—the child approaches the therapist verbally or non-verbally for the purpose of sharing an activity or a conversation e.g. "Let's play house."

   Exception: child engages therapist in an activity because he feels incapable of doing it on his own.

3. Seeks approval—the child seeks reassurance or support that what he does is acceptable to the therapist—verbally or non-verbally.

**Recording Rules**

Each designated behavior that occurs within the 45 minute session will be recorded. The number of times each behavior occurs in the session will be totalled.
Assumptions Upon Which This Study is Based

The problems of the learning disabled child can be defined from various perspectives but any definition describes the values held by the one who does the defining. Built into these definitions are basic assumptions about growth and development, the learning process and human nature. When these assumptions are used to influence programs which affect a child's development it is imperative to make them explicit. In doing this, one must recognize there is often a fine line between knowledge and opinion. "Certain facts seem well substantiated, many are open to question, others remain articles of faith." (Shapiro, 1973, p. 689)

1) A positive self-esteem is essential if an individual is to be academically and socially successful. (Rogers, 1951, 1954; Erikson, 1963; Coopersmith, 1967.)

2) According to Cooper and Wanerman (1977), a basic tenet of the developmental approach is that the growth of cognitive function (problem solving, reasoning) cannot be separated from the growth of personal and interpersonal processes (development of self-esteem, sense of identity, relatedness to others).

3) Research has shown that the self-esteem of learning disabled children is likely to be lower than that of non-disabled children. The individual forms a sense of "self" through his interactions with significant others. The learning disabled child's opinion of himself tends to be a

4) Learning disabled children often react to their difficulties by acting out aggressively or by withdrawing affectively. (Gardner, 1973; Felker, 1974)

5) Social work intervention using the medium of play provides a milieu in which the child is accepted and valued as he is. Within this safe environment, the child builds his sense of confidence in himself - he learns to accept and value himself. (Moustakas, 1953; Axline, 1969; Caplan & Caplan, 1973)

6) As the child's self confidence increases in the playroom he will begin to risk himself outside in the everyday world. (Axline, 1969)

7) When the child's emotional energy is no longer being used in a defensive manner, it can be directed toward growth and learning. (Axline, 1964; Gardner, 1973; Felker, 1974)

8) Children are dependent on parents to provide a home environment that is conducive to their growth and development. Parents who are understanding and supportive help their learning disabled child accept and value himself. (Gilboy, 1981; Kronick, 1981)

9) The parents of a learning disabled child may benefit from discussing their fears and concerns with a social worker. The more understanding they have and the more in-
volved they are in their child's treatment, the better they are able to provide a consistent, secure home life. (Briard, 1976; Haufrecht & Mitchell, 1978; Anderson, 1980)

**Operational Definitions of Terms Used in This Study**

*Self Esteem* is defined as the individual's evaluation of himself; it expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, or worthy, i.e. "It is a personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself." (Coopersmith, 1967, p.5)

*Self Concept* is a "unique set of perceptions, ideas and attitudes which an individual has about himself." (Felker, 1974, p.2) According to Felker, the dimensions of self concept are: (1) body image, (2) cognitive self, (3) social self, (4) self-esteem. It is the total view an individual has of himself.

**Learning Disabilities** are defined by the Ontario Ministry of Education as disorders in one or more of the processes involved in understanding or using symbols or spoken language. The disorder results in a significant discrepancy between academic achievement and assessed intellectual ability, with deficits in at least one of the following areas:

- receptive language (listening, reading)
- language processing (thinking, conceptualizing, integrating)
- expressive language (talking, spelling, writing)
- mathematical computations
Such deficits become evident in both academic and social situations.

The definition does not include children who have learning problems which are primarily the result of impairment of vision or hearing; motor handicaps; mental retardation; primary emotional disturbance; or environmental, cultural or economic disadvantages.

Learning Disability Clases: are designed to meet the unique needs of children who are experiencing specific learning problems. A qualified Special Education teacher and a reduced pupil teacher ratio enables the teacher to plan and implement programs to meet the child's specific needs.

Criteria for admission into a learning disabilities class:

1) Normal intelligence
2) Lag in perceptual and/or motor development
3) Academic retardation
4) Inability to benefit from regular classroom instruction.

Students not included are those whose problem is primarily:

1) Mentally handicapped
2) Behaviorally, socially or emotionally disturbed
3) Severely physically handicapped.
The non-disabled child for the purpose of this study is defined as a child enrolled in a regular classroom and functioning at the expected academic level.

Regular Classroom for the purpose of this study is defined as a class offering the prescribed curriculum and excludes all special education classes.

Remediation is defined as an individualized academic program designed to meet the specific needs of the learning disabled child.

Social Work Intervention for the purpose of this study consisted of:

1) individual 45 minute sessions with the child, held on a weekly basis. A minimum of ten sessions were held within a twelve week period.

2) at least four contacts with the parents to answer questions, offer support, and obtain feedback regarding their observations of the child.

Setting:

A room in the school which the children attend.

Time:

Each child was scheduled to meet with the therapist at a consistent time on a weekly basis, e.g. every Wednesday at 1:30. This provided a sense of predictability and security.

Material Used:

Blanket

Toy Cars

Hand Puppets

Cardboard Box doll house
Play Dough  Watercolor paints
Crayons    Scissors
Dolls        Popsicle Sticks
Family Figures  Glue
Cowboys, Indians & Horses  Paper
Punching Toy  Soccer Ball
Blocks       Board Game (Ups & Downs)
Full Length Mirror (introduced at Session 7 5)
Story Books

Choice of Play Material

Toys allow a child to express concerns, interests, ideas, skills and his view of the world. When selecting materials to be used in the playroom, the child's age and developmental level as well as his therapeutic needs must be considered in order to supply material that will be stimulating, therapeutic and appealing.

Play materials should be simple in construction and durable in order to withstand rough handling in the playroom (Axline, 1947, p. 55)

Unstructured materials such as clay, paints, and crayons, permit creative expression and provide a medium for emotional release.

Inflatable punching toys allow the expression of "pent-up feelings of hostility, rejection and frustration in addition to being thoroughly enjoyable." (Caplan & Caplan, 1973, p. 42)
Caplan & Caplan (1973) recommend building blocks as being "the finest ... play material for children from two to twelve years of age." (p.44) Block play bolsters the child's self image because he can control the structure he creates.

Collage materials such as glue, popsicle sticks, paper and scissors provide the child with the opportunity to create, resulting in a strengthened feeling of self worth.

Dolls, family figures, a doll house and puppets are important because they provide a basis for direct expression of feelings as well as allowing the freedom of recreating and working through past experiences. "Fears, anger, sibling rivalry and other feelings can be directly expressed while the child manipulates in play dramas the various significant individuals in his life." (Moustakas, 1974, p. 7) Male and female figures also serve as useful clues to the child's feelings about sex roles.

Cowboys, Indians and soldiers allow a socially acceptable means of expressing hostility.

Board games and balls allow the child to demonstrate his skills and master the environment.

Keat (1974) describes the use of mirrors as a useful tool in counselling for self concept.

The use of story books helps the child to identify and recognize feelings in a non-threatening manner. "Talking about another person's problem is often a less painful
way to begin thinking about one's own." (Gitterman, 1979, p. 122)

**Population**

The population for this study consisted of children between the ages of eight and ten years, enrolled in a special learning disabilities class in elementary school in Essex County.

This particular age range was selected because it is at this developmental stage that the concept of self-esteem becomes relatively well formed. The child at this level reaches a degree of organization of self which allows him to arrive at a general evaluation of self. (Coopersmith, 1967, p. 5.)

Children of this age possess a level of language comprehension which permits the use of a language based data collection instrument. (Biber, 1969, p. 560) Therefore, a relatively reliable measurement of self can be obtained.

**Sample**

From the defined population, a sample of six students was selected. The classroom used for the sample was selected on the basis of interest in the project expressed by the school principal and the teacher. The six students made up the entire class.

The six children were assigned to two groups - experimental and control. They were randomly assigned to these groups. The experimental group consisted of three boys,
while the control group was made up of one girl and two boys.

Limitations of the Study

Limitations of the study will be discussed in four (4) areas.  
1) Sample Size  
2) Sample Selection  
3) Follow up  
4) Measurement Instruments

Sample Size

Because of the small sample size, generalizability of the results of this study are limited. In an effort to compensate for the small numbers, the subject characteristics were clearly described and the method of intervention was outlined in detail.

General agreement has not been reached as to what constitutes an adequate size. Seaberg (1981, p. 90) states that a sample of one tenth the size of the population will give reasonable control over sampling error.

Sample Selection

The classroom sample of six children was chosen because of interest expressed in the project by the principal and the classroom teacher. This may impose limitations on the generalizability of the results. The children were randomly selected for the control and experimental groups. The children are considered to be representative of the population since they meet the admission criteria of the learning disabilities class.
Follow Up

The question of follow up was not addressed. This would have determined the stability of the attitudinal and behavioral changes.

Measurement Instruments

The Coopersmith Self-Esteem Inventory (S.E.I.) relies on the child's willingness and ability to tell the examiner how he evaluates himself in different areas.

Bailey, (1973, p. 257) identifies potential sources of error in self reported data. Subjects may:

1) be unwilling to admit socially undesirable feelings, attitudes or traits.

2) misunderstand or misinterpret the question

In an attempt to counteract these potential error sources, the teacher endeavored to create a relaxed atmosphere and offered reassurance that the subject would not be adversely affected by revealing sensitive spots. She answered any questions the children had about the items to ensure that the child understood them.

In addition, the scale controls somewhat for acquiescence - response set by including an approximately equal number of favorably and unfavorably worded items. (Wylie, 1973, p. 170) No item analysis or internal factor analysis has been performed by Coopersmith.
The Coopersmith Behavior Rating Form (B.R.F.) relies on the teacher's appraisal of the subject's behavior and appearance. Teachers' perceptions reflect basic attitudes toward the child and although teachers attempt to maintain objectivity, the subjective aspect of evaluation cannot be ignored.

Lack of control for the Hawthorne effect presents a threat to external validity. The fact that they are included in a study may have a positive effect on some subjects, i.e. the child's self-esteem may increase merely due to the fact that he was selected to participate in the study.
DESCRIPTION OF INTERVENTION

Goals

In the treatment of children, specific goals and methods of intervention must be defined within the context of the individual's unique needs. However, certain general goals and principles of intervention can be outlined. Because of the recognized importance of positive self-esteem the ultimate aim with these children was to increase their self-esteem. The means by which this primary goal could be met were that each child will:

1. recognize and utilize the capacities that are within him
2. develop a realistic perception of self and his impact on his environment.
3. develop positive expectations of self while recognizing his limitations.
4. develop appropriate adaptive mechanisms for meeting his needs.

For each child there were more specific, individual goals. Grant needed to learn to recognize and appropriately express his feelings of fear and anger instead of directing his anger at himself. His high state of physical tension indicated that he could benefit from learning to relax as a means of overcoming anxiety.

Patrick's sub goal was to develop more self-confidence and a more assertive attitude so that he will be less of a follower and consequently will feel less helpless.
Jimmy needed to decrease the perfectionist demands he places on himself and to accept that his areas of learning weakness do not mean he is lazy or stupid. If these aims could be achieved, Jimmy would have less need for denial and could allow himself to express his feelings more directly.

General Principles of Intervention

Virginia Axline (1969) outlines eight basic principles to serve as a guide for non-directive play therapy. In this study, a combination of directive (structured) and non-directive techniques was used. The following principles defined by Axline were incorporated into the intervention technique:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those back to him in such a manner that he gains insight into his behavior.
5. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (p. 76-135)
Initially, the sessions were non-directive in nature. Directive play was introduced when the relationship developed to a point where the therapist had assessed the need for specific techniques and the child had developed a feeling of trust and security.

Directive intervention took the form of the therapist introducing new topics of conversation, suggesting certain activities or using certain play materials, initiating or modelling certain types of play, e.g. puppet play; remembering at all times that these methods were not imposed on the child - the child was given choices.

Directive play was always followed by a period of non-directive play. The sessions were set up in the following sequences depending on the needs of the child:

1. Directive Play -- non-directive play
2. Non-directive play -- directive play -- non-directive play.

When the child was introduced to the therapy room, an explanation of the nature of the sessions was given:

"In this room you may play with any of the toys you want. You can play with the toys in any way you want. Part of the time we spend together will be spent talking. You can talk about anything you want - things that are bothering you, things that make you happy or sad - everything you say is O.K. Sometimes I might bring up some things for us to talk about. This is a place where you can play and talk and learn to be happier with yourself."
Interpretation was limited to conscious meanings and was usually confined to what the child said or did during play. He was not confronted with the meaning of his play in theoretical terms.

Limit setting is an important aspect of intervention with children. Limits were few, consistent and specific. The child was permitted to play freely within limitations appropriate to the real world. Limit setting was done as the need arose, e.g. the children were not permitted to break the toys or to take them home.

Throughout the session, the therapist was aware of the process of the child's play, remembering that the way the child behaves in the playroom is a microcosm of how he is in the real world. A chart of certain indicators of self esteem was kept for each child during each of the sessions. (See Appendix E) The following behaviors were observed:

1. makes negative statements about himself.
2. engages therapist in play activities or conversation.
3. seeks approval

Each session was audiotaped to ensure accurate recall of the interaction.

Contact with parents involved an initial home visit to answer questions and explain the nature of the intervention, followed by phone contact to answer questions and
obtain feedback about the child's behavior every three weeks
with the option of a home visit given to the parents.
Parents were free to contact the therapist throughout the
12-week period.

Summary of Individual Sessions

Gran't

Grant's high level of anxiety was clearly evident
when he entered the playroom for the first time. His
muscles were tense, he avoided eye contact, made many
facial gestures and made no attempt to approach the toys,
although he did look at them with interest. Non-verbally
he sought the therapist's approval as he looked from the
toys to her. When he felt sufficiently reassured that it
was O.K. to do so, he set out the Cowboys, Indians and
horses and arranged them according to color. Grant played
with these toys at every session and although the manner
in which he arranged them and the amount of time he spent
with them varied, the basic theme of his play with them
remained the same. One figure always emerged as the
strongest, invincible one who won all the wars and killed
everyone else. This figure was initially a horse but was
replaced by a Cowboy after the fifth session. This theme
which was re-enacted in Grant's other play revealed his
feelings of helplessness and inadequacy and his wish to be
the strongest, most powerful figure.

In the third session, Grant verbally expressed his
feelings of anger and rage - directing these feelings first at himself, then at animals and finally at "everyone in the world." Grant's use of the punching toy increased in both time and intensity. The following excerpt is from the third session:

Grant: I mean it - he's going to die (while kicking the toy.

Therapist: You're going to kick him until he dies.
Grant: I don't kick people, just punching bags.
Therapist: You don't kick people
Grant: I hit them and I lock them in the closet.
Therapist: Then what happens?
Grant: I put a match in the closet and burn it.
(looks for therapist's reaction and quickly adds) It's not for real.

This interaction served as a means of releasing aggressive feelings and it also provided a basis for a discussion of how to deal with anger in acceptable ways.

Grant's ambivalence toward maternal figures was demonstrated in his play with the female figure. He repeatedly had the boy and father figures shoot and attack her. He ran the car over her several times then put the boy figure beside her and allowed her to be alive. He repeated this play for three sessions. The therapist reflected and described the play but made no effort to interpret it to Grant. The fourth time he played with the doll family, he
played briefly and non-aggressively and did not play with them again until the final session.

Grant's play was always expressive, reflecting his fears, fantasies and realities. Verbal expression increased markedly as he became more trusting.

Grant was receptive to learning a relaxation exercise and practiced this during the last four sessions.

Initially the therapist initiated all interaction. At session #3, Grant was able to initiate and engage the therapist in a conversation.

In contrast to his usual reticent behavior, when the therapist was engaged in play with him, Grant demanded complete control of the play situation. He was able to use her as a symbol of authority against which he could express the feelings he ordinarily repressed.

Grant set up the Cowboys and Indians. He directed the action and made certain his guys won. The following interaction took place when one of the therapist's Cowboys attacked Grant's men.

Grant: You can't kill him, he's made of steel
Therapist: He's too strong to die (attacks another cowboy)

Grant: That's not fair - you can't do that.
Therapist: O.K. You tell me what I can do.
Grant: Anything - but you can't go in that house.

They're safe in there.
Lots of shooting and killing follows, with much direction from Grant.

Grant: You have to be dead.

Therapist: O.K. I'm dead.

Grant: I won - your guys can all be alive again.

Grant enjoyed the use of mirroring procedures particularly the technique of the Magic Box (a small box with a mirror placed in it to reflect the face of anyone looking into the box) although he had difficulty acknowledging that he is special.

The therapist talked about individual qualities that make each person special. This was followed by:

Therapist: Who do you think is the most special person in the world.

Grant: asked several questions to ensure he didn't get the wrong answer eg. "Is it a man?" "You mean the strongest?" finally refusing to guess "I don't know."

When the therapist showed him the magic box --

Grant: (smiling) It's me. It's a trick - but it's not me. I'm not special.

Grant went on denying that he could be a special person while the therapist was pointing out the unique qualities that do indeed mark him a special person. However, in the next session, Grant proudly reported that he had done his mirror homework several times. Grant places extremely high standards on himself and rather than falling short, he withdraws and then becomes frustrated with himself.
Toward the end of the sessions, Grant maintained eye contact with the therapist and had a relaxed body posture. He continued to express a lot of aggression but was able to balance this with positive play. The cruel, violent nature of his play that was exhibited in the early sessions disappeared as he became more verbal and more relaxed.

Grant's goals were only partially met and recommendation was made for continued therapy. This would be aimed at reducing his anxiety and aggression and helping him learn to deal appropriately with his feelings.

** PATRICK **

Initially Patrick's desire to please the therapist interfered with his spontaneous play as he frequently sought her approval before choosing a toy or hitting the punching bag. As he became more familiar with the permissiveness and with the fact that acceptance would not be withdrawn, he risked himself and engaged in some aggressive play with the puppets, the family figures and the punching toy. Patrick had difficulty accepting the limit that toys were not allowed to be taken home by the children. Beginning with session 5 he consistently requested to take the play materials with him at the end of the session. He also needed to be reminded 2 - 3 times when it was time to return to the classroom at the end of the session. This behavior persisted to the last session. This behavior indicated that termination would have to be handled with special care.
Patrick was permitted to take home the articles he created in the sessions, as were the other children. The therapist dealt with Patrick's requests by repeating that the toys were not permitted to be taken home by anyone and by reflecting that indeed it is hard to leave a place when one is having fun.

Patrick told the therapist of a newspaper story about an abandoned baby. He was quite upset over this and a discussion ensued about how mothers sometimes are unable to care for their children. He was very solemn when he proclaimed: "my mother wouldn't ever do that." He was able to admit that this was something he thought about sometimes. Patrick's creativity was expressed in his play - he made play dough figures and puppets, he painted pictures and told imaginative stories. As the sessions progressed, Patrick was able to talk about his fears and how he deals with them, often by pretending to be a superhero.

Patrick: Sometimes I dream about monsters (he becomes very active at this point, running to the punching toy and hitting it, making lots of eerie noises.)

Therapist: That sounds scary.

Patrick: When I sleep and I wake up after I see a scary movie, I think I'm going to die. You know what I do? I put on my Superman mask.

Therapist: and scare the monsters away.

Patrick: Sometimes I hear shooting noises and I get dreams you and me are here and monsters are around here
and the puppets come alive and are throwing knives at us.

Therapist: and what are we doing?

Patrick: running away (laughing)

Therapist: that sounds like a smart thing to do.

Patrick has a keen sense of fantasy and humor that came out in his stories, in his play and in his teasing of the therapist. A discussion of how to deal with scary dreams and thoughts followed this encounter.

Story books were used to initiate and structure the talk section of some of the sessions. The following example is from the eighth session when the therapist is introducing a new book about a learning disabled child. Patrick had denied having any problems at school up to this time. The therapist felt that Patrick had developed enough trust in their relationship to risk talking about his difficulties. She hoped the book would serve as a safe vehicle for Patrick to take off from and apply to himself.

Therapist: Do you like reading?

Patrick: Not that much, I just like looking at the pictures.

Therapist: It must be tough when you try to read and have a hard time.

Patrick: Sometimes I'm trying to read and I just stop - people get mad when they don't know how to read (while he is talking, Patrick is playing with the play dough - kneading and punching it).
Therapist: Do you ever get mad at yourself?  
Patrick: (nods yes)  
Therapist: Sure and you think "Why can't I read?"  
Patrick: I want to go back to my own school.  
Therapist: You miss your school - will you go back when you learn to read?  
Patrick: and when I learn my times tables.  
Patrick explained how hard it is for him to do arithmetic and reading.  
Therapist: It must be really hard for you. I'm sure you try hard and sometimes you still don't get it.  
Patrick: (shakes his head yes, continues punching the play dough)  
Therapist: Do you know what that's called?  
Patrick: No - what  
Therapist: a learning disability. Have you ever heard that word?  
Patrick: No.  
Therapist: I have this book about learning disabilities, it's called "I am not dumb."  
Patrick: (giggles) Kids say I'm dumb because I don't know how to read that much.  
Therapist: That happens a lot. It happens so much that someone even wrote a book about it.  
Patrick: I get mad and I run after them and say, "you are a dumb dumb because you can't read either."
The therapist chose not to deal with the issue of how to respond to teasing at this time but rather to remain focused on Patrick's perceptions of himself.

Therapist: Do you think you're dumb because you don't know how to read?

Patrick: (in a whisper) No. (then a little louder) No-some mothers say they aren't. (very softly) my mother says I'm not.

Therapist: and she's right - just because someone has a hard time doing something doesn't mean they are dumb. (gives example of herself playing soccer, a sport at which Patrick excels and therapist has a hard time.) Would you like to go through this book?

Patrick: I'm going to ask my mother to buy it.

Time ran out and the story was read the next week. Patrick listened attentively to the story but rather than apply it to himself, he chose the safer route and applied it to his friends. One of the benefits of using a story is that it allows the child the safety of projecting personal feelings onto a third person.

Patrick developed a pattern to his sessions whereby each session ended with a soccer game between him and the therapist. This provided him with a feeling of pride as he demonstrated his skill and taught her how to play.
JIMMY

Jimmy has exceptionally high verbal skills and he generally chose to talk rather than to play during the non-directive periods of the sessions. However, he often used play as a secondary activity while he talked, e.g. playing with the clay, occasionally punching the plastic clown. This may have provided him with a means of releasing tension enabling him to express his pent up feelings. Initially, Jimmy's conversations dealt with his after school activities and his home life. He was eager to impress the therapist and avoided any mention of his academic difficulties.

During the sixth session, Jimmy was able to say that he has a hard time reading and to talk about how it feels to have a learning disability. The following is an excerpt from session # 6.

Jimmy was angry when he came into the playroom. He immediately recounted an incident that had occurred at recess earlier in the day. He had been angry at a classmate who had broken the class football. This lead to a discussion of appropriate ways of dealing with anger and then in turn led to the topic of his being teased because he has trouble learning.

Jimmy: It bugs me when people say I'm not trying - I say "shut up or you won't have a face left."

Therapist: It makes you pretty mad when people don't
seem to understand.

Jimmy:  (shakes his head yes emphatically while pounding the clay into a styrofoam cup)

Therapist:  Can you tell me what you know about learning disabilities?

Jimmy:  It feels like you're stupid.

Therapist:  Because you can't get the words right?

Jimmy:  (very softly) yeah-yeah (continues pounding the clay)

A discussion of individual strengths and weaknesses followed this encounter. Jimmy was able to identify his strengths and hopefully to begin to recognize that having a learning problem is not synonymous with being lazy or stupid. This theme continued for the following two sessions with Jimmy struggling to change his perception of himself as being lazy and stupid. In the seventh session, Jimmy was further able to risk himself by asking if he and the therapist could read a story together. They read "I am not dumb," a story about a child with learning disabilities.

Jimmy reacted strongly to termination. At session #8 the therapist gave him a calendar showing the number of remaining sessions and explained that she would be leaving. Jimmy was not able to directly express his feelings about termination until the last session. However, his play during the intervening sessions clearly demonstrated his
emotions. His ambivalent feelings toward the therapist were expressed in the puppet play which he directed. He had two puppets while the therapist had one. One of Jimmy's puppets wanted to be friends with the therapist's puppet while the other wanted to fight. A battle ensued during which the therapist's puppet was beaten by Jimmy's puppets. At the end of the play all three became friends.

Termination often presents an opportunity for the child to relive and rework past separations. Jimmy talked about his move from his home school to the one he presently attends and he talked about the future when he will be returning.

Although Jimmy was always verbal, the content of his conversations changed markedly as the sessions progressed; from superficial chatter and denial of any negative feelings of problems to direct expression of his frustrations and anger. This expression then led to discussions of effective and appropriate ways of dealing with anger. Gardner (1973) states that the therapist must help the child recognize that there are times when their efforts to change the cause of their frustration will be successful, but also that there will be times when they will not be successful, "Then, they must be taught to resign themselves to their failures and to seek substitutive gratifications." (p.138) The following excerpt from session #9 illustrates Jimmy's attempt to deal with his frustration over not completing
his math work. Jimmy looked downcast and quiet when he came into the room and when the therapist commented on this he replied:

Jimmy: I don't care. I feel like throwing my math away.

Therapist: You sound pretty fed up.

Jimmy: (nods yes)

Therapist: Math is pretty hard for you.

Jimmy: Especially my new book — it's really hard (describes the type of work he is expected to do). It takes long.

Therapist: Can you finish it at home?

Jimmy: No, my mom screams (imitates mother screaming)

Therapist: She wants you to do it at school.

Jimmy: She wants my work done. I try to hide it from my teacher (describes how he does this) I wish I had a big garbage pail and I could put all my new books in it.

Therapist: You'd like to get rid of all that aggravation.

Jimmy: They'd say "where'd your books go?" and I'd say "beats me."

Jimmy described the math problems he was facing and talked about how stressful it is for him to have a time limit put on this work that he does not understand. He described how his classmate deals with this pressure.

Jimmy: Sarah gets it done. She's like me but she gets people to help her or else she copies.
Alternative ways of dealing with this frustration were discussed.

At this point Jimmy decided he would like to paint so he laid on the floor on his stomach and painted a black and brown geometric design which he refused to talk about.

The session concluded with Jimmy and the therapist hitting the punching toy back and forth while talking about ways of dealing with anger.

All three children revealed various degrees of feelings of helplessness as well as wishes to be "the biggest, the strongest and the most powerful." These feelings and fantasies are common to all children but are certainly more poignant in the child who is struggling with a learning disability in addition to the regular developmental crises of childhood.

It is hoped that social work intervention helped these children gain a better understanding and acceptance of themselves - their strengths and weaknesses - and through this to gain a better understanding and acceptance of all people.

Description of Parent Contacts

Initially the therapist contacted all six parents by phone in order to introduce herself. A home visit was arranged with five of the families. The sixth parent felt she received sufficient information via phone. In four instances contact was only with the mother. Both parents were involved in the remaining two cases.
At the initial visit, the therapist explained the purpose of the research project and described the planned intervention. The parents were interested in the study and eager for their children to participate. At this visit, the parents were asked to briefly describe their family in order to help the therapist understand the environment in which the child lives.

The parents of the experimental group were contacted by phone four times during the twelve week period of intervention. They were free to contact the therapist at any time during this period.

A variety of themes were discussed including, anxiety about the child's future, guilt over perhaps being the cause of the child's learning problems, concerns about the child's academic progress and attitudes about the school system.

The therapist encouraged the parents to approach the classroom teacher with their specific academic questions. One mother was especially reticent about doing this, using several excuses such as not wanting to be a nuisance, not having the school's phone number, etc. The therapist wrote out the phone number and agreed to prepare the teacher for the parent's phone call. Finally the mother did speak with the teacher and was very pleased that she was able to carry this through.
The parents provided information about the day to
day events that were occurring in the child's life. This
information provided a broader base for understanding of
the child.

Explanation of the child's behavior was provided
when it was deemed appropriate, always maintaining the
rules of confidentiality. In response to one mother's
complaints of her child being too unmotivated and lazy
to learn, the therapist explained how fear of failure
can often prevent a child from trying thus giving the
appearance of not caring.

The needs common to all the parents were for someone
to listen and understand as they expressed their frustra-
tions and their fears, someone to offer support and help
them recognize their positive parenting skills and per-
haps most important of all to help them recognize and
build on their child's strengths rather than focusing only
on his weakness.

Teacher Involvement

The classroom teacher was extremely cooperative and
met with the therapist five times during the twelve weeks
of intervention. The purpose of the meetings was to share
significant impressions that emerged from both the inter-
vention and the class content.
Summary

A classical experimental design was used to test the hypothesis that social work intervention together with remediation will increase the self-esteem of learning disabled children. Six children from a specific learning disabilities class were randomly divided into an experimental and control group. Three instruments were used in an effort to obtain an accurate measure of self-esteem: the Coopersmith Self Esteem Inventory; the Coopersmith Behavior Rating Form and observation of indicators of self-esteem during intervention.

Pre and posttest measures of the S.E.I and B.R.F. were obtained for both groups. Intervention consisted of weekly 45 minute sessions with each child in the experimental group. A minimum of ten sessions was held over a period of twelve weeks. Play was used as the primary medium in the intervention together with a combined directive and non-directive approach. General and individual goals were set for the children. Contact was maintained with the parents during the period of intervention.
CHAPTER IV

RESEARCH FINDINGS, ANALYSIS AND DISCUSSION:

This chapter provides a description of the sample used in the study as well as an account of the data analysis procedures that were used. The findings are presented and accompanied by tables or figures followed by a discussion of their significance. A description of the progress observed during intervention by the therapist is included. A post intervention description of the children by the parents and teacher concludes the chapter.

Sample Description

The six children who were involved in the study are members of a Junior Level special learning disabilities class. Five of the children have been in this class for a period of one year while one has been in the class for eighteen months. All of the children have failed one grade (four repeated grade one, two repeated grade two) and received remedial instruction prior to placement in this class. They all live outside the school community and are transported to school by bus.

They have all been assessed as having a normal I.Q. ranging from 79 to 104 on the Slossen Intelligence Test with a mean of 92 and a range of 77 to 92 on the Wechsler Intelligence Scale for Children - Revised (W.I.S.C.R.) with
a mean of 83.16. The average discrepancy between verbal and performance components of the W.I.S.C.R. was 14.2 points.

Three of the children had been identified as "high risk" on their Early Screening Profiles. Two of the children had previous social work involvement - one for adjustment problems in grade one and one for an assessment when he was placed in the learning disabilities class.

They are all from middle class, urban backgrounds and all are members of 2 parent families. Three of the children have a Canadian background and three have a European heritage with English spoken as a second language in the home. All but one of the children were born in Canada. According to prior assessments, their ethnic backgrounds are not seen as being the principle cause of their school or language problems.

Their specific learning disabilities were identified as being in the areas of: long term memory of general cultural information; short term auditory sequential memory; visual analysis and synthesis of patterns; slight co-ordination problems. These disabilities are manifested mainly in the language arts (reading, spelling) and mathematics areas.

Experimental Group

Patrick has one sibling, an older sister who has no learning or behavior problems. His parents appear to have
a stable marriage and they expressed much concern over Patrick's academic prognosis. They have difficulty recognizing the affective needs that are linked to learning disabilities and consistently redirected attempts to discuss Patrick's emotional needs to more concrete factors such as homework and the return to his home school.

Patrick is described as a solemn child who does not smile readily. He is co-operative and eager to please and his teacher states he is "a follower" who is easily led by his peers. Patrick's desire to please also drives him to work hard and to persist in staying on task in the face of difficulty and frustration. Patrick has much difficulty in the language arts area with a slightly lesser degree of trouble with arithmetic. He excels at sports and is excited about joining a soccer team.

Grant is in the middle of a sibship consisting of a younger brother and an older sister. Both sibs are described by their parents as being "very bright and outgoing." Grant's parents expressed concerns about his future ability to fit into the job market and into society. His mother is admittedly unhappy in her role as wife and mother - a role in which she feels trapped due to her husband's strong objections to her seeking work outside the home. Grant's father blames his son's poor academic skill and behavior problem on his wife and she accepts that it is her fault. She describes Grant as
having "two sides" - one "sweet and sensitive" and the other "demanding and angry." She states Grant remains physically close to her when he is not at school and that he demands much attention from her. She expresses ambivalence about this situation, admitting that she enjoys it but at the same time recognizing his need to become more independent.

Grant's early screening profile indicated very serious difficulties and this prediction certainly was borne out. His primary problem area is defined as a communication disorder, particularly in the area of expressive language. He received speech correction for six months and although progress was reported, speaking remains a real effort for Grant. He does not usually initiate conversation and he typically answers in words rather than sentences. Grant is often unable to think of the appropriate word. His frustration as he struggles to come up with the correct word is evidenced by his facial grimaces, his tightening body posture and finally his giving up by either withdrawing or swearing.

In addition to his language problems, Grant has much difficulty with arithmetic as well as difficulty with spelling and reading. He is a timid, fearful little boy who avoids eye contact.

Grant reacts to his learning deficiencies by withdrawing or by attention seeking behavior such as giggling,
swearing and clowning. Due to his immature behavior, Grant is not accepted by his peer group who consider him a nuisance.

Jimmy is the youngest in a family of six children, 4 boys, 2 girls. His older sister (18) is described as having "a hard time with school work" although she is not diagnosed as learning disabled. Jimmy is described as being quiet and passive at home, never causing any problems and never needing to be reprimanded, quite the opposite of the other children who are described as "noisy, outgoing and troublemakers." His parents appear to blame his "easygoing lazy nature" for his learning difficulties and they feel that if he really tried he would do well in school. His mother expressed dismay that Jimmy brings home primary level books and enjoys reading them when she feels he should be reading at a higher level.

The label of "lazy" has been used often to describe Jimmy, so often that he has internalized it and describes himself in this way. In reality, Jimmy is a talkative outgoing boy who demands perfection from himself and who quits rather than face the risk of not being able to achieve. This often leads to his seeming to be unmotivated.

Jimmy's visual memory problems affect his reading, spelling, written work and arithmetic. He denies having any problems. Jimmy has a good memory and is able to remember facts gleaned from discussion, movies, pictures.
He enjoys taking part in discussions.

Jimmy has chronic allergies since the age of 2 years and is under the care of an allergist. He excels at sports, but has not been allowed to participate in community based hockey and baseball teams because his parents fear this interferes with his school work.

**Control Group**

Peter has an older sister who is doing well in school. His parents have a hard time understanding the concept of learning difficulties and consequently are not very supportive to Peter in this area. He has limited math and reading skills and is weak in vocabulary and verbal fluency. This language disorder impedes his participation in class discussions. He is socially immature and impulsive and expresses his frustration by clowning or by teasing his peers. This behavior makes him unpopular with his classmates. Peter is creative and enjoys making up stories.

Sarah has a younger brother who is achieving well at school. Her parents have a good understanding of learning disabilities and provide Sarah with encouragement and support. She had difficulty adjusting to grade one and was seen by a social worker intermittently during that year. Currently she presents as a happy child who is eager to attend school and who integrates well with her peers. Sarah has particular difficulty in the language
arts area of reading and spelling. She gets frustrated easily and tends to copy from her classmates when she perceives the task as too difficult. She has shown much improvement, is achieving well and will probably return to a regular classroom in September.

Todd is an only child. His family has a close relationship and the home situation could be described as "ideal." His parents have read extensively about learning disabilities and they try to help Todd cope with and compensate for his particular learning deficiencies. Todd has serious difficulties in visual and auditory modalities, as well as with memory and concentration. These difficulties are manifested in poor language arts and arithmetic skills. In addition, he has a social perception problem and has difficulty meeting the basic social demands of everyday life. Todd often responds inappropriately and seems to display a shallow affect. At the same time, he is a friendly, talkative and co-operative child.

Todd has a history of chronic ear infections.

Data Analysis Procedures

The hypothesis used in this study was examined by looking at the relationship between social work intervention and the self esteem of the learning disabled children who comprised the sample. The pre and posttest scores obtained on the Self-Esteem Inventory were compared for the experimental and control group. A \( \chi^2 \)-test was done to
determine the presence of an association between the increased scores and the intervention.

The pre and post intervention scores on the teacher's Behavior Rating Form were compared for both groups and a $r$-test was performed to define a relationship between the intervention and the increased scores.

Pearson's $r$ was used to describe the strength of association between the Self-Esteem Inventory scores and the Behavior Rating Form scores.

The frequency of self-esteem indicators observed during the intervention is presented in graph form. The data is followed by a brief discussion of the pertinent observations.

Self-Esteem Inventory Scores

The range of pre and posttest scores obtained on the S.E.I. is presented in Table 1. The increases in self-esteem scores of both groups may be partially accounted for by the classroom teacher's increased awareness of affective needs and emphasis on esteem enhancing teaching methods. The teacher stated she was more cognizant of the children's areas of weaknesses when setting academic goals and thus was able to build in more "success" experiences. This would lead to a sense of mastery and increased feelings of worth. This incidental but important effect on the teacher is an intervening variable that would be expected in any classroom setting. This issue is addressed by Piske,
Hunt, Luborsky, Orne, Parloff, Reiser and Tuma (1970) who state: "A major problem in assessing the outcome of therapeutic treatment is determining the effects contributed by sources other than the client." (p. 32) Piske et al conclude that generally these effects are controlled by random assignment of subjects, which was done in this study.

Table 1

<table>
<thead>
<tr>
<th>Child</th>
<th>Group</th>
<th>Pretest Score</th>
<th>Posttest Score</th>
<th>Degree of Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>C</td>
<td>29</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td>Todd</td>
<td>C</td>
<td>12</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Peter</td>
<td>C</td>
<td>8</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Grant</td>
<td>E</td>
<td>8.28</td>
<td>14.8</td>
<td>6.52</td>
</tr>
<tr>
<td>Patrick</td>
<td>E</td>
<td>7.71</td>
<td>18.66</td>
<td>10.95</td>
</tr>
<tr>
<td>Jimmy</td>
<td>E</td>
<td>10.66</td>
<td>30</td>
<td>19.34</td>
</tr>
</tbody>
</table>

Nota: Maximum score = 100
Table 2

Mean Scores On S.E.I. of Control and Experimental Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Pretest</th>
<th>Mean Posttest</th>
<th>Degree of Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>16.33</td>
<td>23.33</td>
<td>7.0</td>
</tr>
<tr>
<td>Experimental</td>
<td>8.88</td>
<td>21.15</td>
<td>12.27</td>
</tr>
</tbody>
</table>

The literature points out that self-esteem is an unusually stable variable and that changes in self-esteem are difficult and slow to effect. (Coopersmith, 1967; Briggs, 1970) The increases in self-esteem scores of the experimental group suggest that social work intervention may augment the growth of positive self-esteem.

The Self-Esteem Inventory can be subdivided into two sections - 1) general self-esteem scores
2) lie scores (indicators of defensiveness).

Table 3 illustrates that general self-esteem increased in most of the children while the lie scores for the most part decreased.
Table 3
Pre and Posttest Scores of Experimental and Control Children On General Self-Esteem Items and Lie Items

<table>
<thead>
<tr>
<th>Child</th>
<th>Group</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Lie Score</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>C</td>
<td>58</td>
<td>62</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Todd</td>
<td>C</td>
<td>72</td>
<td>84</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Peter</td>
<td>C</td>
<td>40</td>
<td>54</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Grant</td>
<td>E</td>
<td>58</td>
<td>74</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Patrick</td>
<td>E</td>
<td>54</td>
<td>56</td>
<td>7</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Jimmy</td>
<td>E</td>
<td>64</td>
<td>60</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Maximum Self-Esteem Score = 100
Maximum Lie Score = 0

The lie scores, which indicate defensiveness decreased to a greater degree in the experimental group suggesting that intervention helped these children become more accepting with a subsequent decreased need to cover up their weaknesses. Defenses are built up around weakness and serve to protect an individual from anxiety, fear, inadequacy or insecurity. (Briggs, 1970, p. 35) When a child's energy is freed from maintaining unhealthy protective defenses, he is able to place more of a focus on learning and positive growth.

One of the assumptions of this study is that learning disabled children have lower self esteem than non-disabled children. This is demonstrated by comparing the range of scores obtained in this study with scores obtained in
previous studies done by Coopersmith (1969) and Thompson and Hartley (1980). This comparison is outlined in Table 4.

Table 4

Comparison of Range of Scores, Means and Standard Deviations on General Self-Esteem of Learning Disabled and Non-Disabled Children

<table>
<thead>
<tr>
<th></th>
<th>Coopersmith Study</th>
<th>Thompson, Hartley Study</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non L.D.</td>
<td>Non L.D.</td>
<td>L.D.</td>
</tr>
<tr>
<td>Range of Scores</td>
<td>40-100</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mean</td>
<td>82.3</td>
<td>75.0</td>
<td>63.1</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>11.6</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

Note: Maximum Score = 100

A t-test was used to compare the amount of improvement in the S.E.I. scores of the two groups of children to determine the presence of an association between the increased scores and social work intervention. Based on the obtained values there is not sufficient evidence to support the hypothesis that social work intervention used as an adjunct to remediation will increase the learning disabled child's self esteem. t(5) = 0.839, p > .05.
Behavior Rating Form Scores

At the end of the twelve weeks, all but one of the control group children obtained increased scores on the B.R.F. These scores are illustrated in Table 5. The overall increase was greater for the experimental group.

Table 5

B.R.F. Scores of Experimental and Control Group Children

<table>
<thead>
<tr>
<th>Child</th>
<th>Group</th>
<th>Pretest Score</th>
<th>Posttest Score</th>
<th>Degree of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>C</td>
<td>11</td>
<td>12.33</td>
<td>1.3</td>
</tr>
<tr>
<td>Todd</td>
<td>C</td>
<td>20</td>
<td>17.2</td>
<td>-2.8</td>
</tr>
<tr>
<td>Peter</td>
<td>C</td>
<td>5.4</td>
<td>10.85</td>
<td>5.45</td>
</tr>
<tr>
<td>Grant</td>
<td>E</td>
<td>5.0</td>
<td>5.4</td>
<td>.4</td>
</tr>
<tr>
<td>Patric</td>
<td>E</td>
<td>5.5</td>
<td>10</td>
<td>4.5</td>
</tr>
<tr>
<td>Jimmy</td>
<td>E</td>
<td>3.5</td>
<td>13.66</td>
<td>10.16</td>
</tr>
</tbody>
</table>

Note: Maximum Score = 33.3

A t-test was used to determine whether there was a correlation between increased B.R.F. scores and social work intervention. The obtained value indicates there is not sufficient evidence to support this hypothesis. t (5) = 1.002, p > .05.

Although the scores of the experimental group increased to a greater extent than did the scores of the control group,
the association between intervention and the increase in scores was not statistically significant. This result is anticipated by Fiske et al (1970) when they describe the inherent problems of using small samples, "These experiments will ordinarily have findings which do not reach the usual levels specified by 'statistical significance'." (p.28) They advise that more complex research designs need to be worked out in order to solve this problem.

**Correlation Between B.R.F. and S.E.I. Scores**

Pearson's *r* was used to describe the strength and direction of association between the teacher's rating of the child's classroom behavior (B.R.F.) and the child's subjective self-esteem rating (S.E.I.). The obtained value indicates the existence of a moderate positive relationship between the two variables. (*r* = .639).

This value is in agreement with the findings of Cooper-Smith (1969) and Reynolds (1980) that self-esteem demonstrates a moderate relationship with classroom behavior.

**Indicators of Self-Esteem Observed During Intervention**

At the end of the twelve weeks, all three children showed a decrease in the number of indicators of low self-esteem and an increase in the behavior indicating positive self-esteem. This suggests that within an atmosphere of acceptance and security the child can learn to accept himself and to interact in a spontaneous, trusting manner. A description of each child's progress in the specified behaviors is illustrated in the accompanying figures.
Grant

Figure 1 illustrates that as Grant's negative self-perceptions decreased, his approval seeking also decreased. At the same time, he increasingly engaged the therapist in play and conversation. The sessions during which Grant expressed the most negative self-statements were the sessions during which his play reflected the most hostility and violence. Session six seemed to be a turning point for Grant. It was at this session that he began to demonstrate some positive attitudes in his play. These observations verify that a child's self-perceptions are reflected in his behavior.

Figure 1: Frequency of Self-Esteem Indicators During Intervention

Note: ______ = negative statements
------- = engages therapist
------- = seeks approval
Figure 2: Frequency of Self-Esteem Indicators During Intervention

Note:

--- negative statements

- seeks approval

Session Number

1 2 3 4 5 6 7 8 9 10 11

Frequency
The steady decline of Patrick's approval seeking as shown in Figure 2 is especially significant for this little boy whose behavior is so often influenced by his desire to please others. This may indicate an increased self-confidence and a decreased reliance on external evaluators.

Jimmy

Figure 3: Frequency of Self-Esteem Indicators During Intervention

Note:  
--- negative statements  
----- engages therapist  
....... seeks approval
Figure 3 illustrates that Jimmy's behavior followed the trend of the other two children, i.e. positive indicators increased while the negative indicator decreased through the course of the intervention.

**Description of Progress During Intervention**

All three children readily adapted to the new routine of weekly intervention. Each child had his favorite toys but generally the punching toy and the play dough were the favorite materials used to express feelings and the soccer ball was used in almost every session to demonstrate skill. Toward the end of the sessions, Jimmy and Patrick were more realistically aware of their strengths and problem areas and were more prepared to discuss them. Grant had not yet reached this point but was learning to deal with his fears and feelings of frustration and anger.

Jimmy's greatest change occurred in the area of defensiveness as indicated by his ability to admit he has a learning problem, his ability to discuss the accompanying feelings and finally to risk himself by reading with the therapist. This decreased defensiveness was further illustrated by the substantial decrease in Jimmy's posttest lie score (decreased by 4 points). At the end of the twelve weeks, Jimmy was beginning to question the false negative perceptions he had of himself of being lazy and unmotivated and to replace these with a more realistic picture of him-
self. Perhaps this was happening with his parents as well, since Jimmy reported they had relented in their decision to not allow him to participate in community sports and he was planning to sign up for a baseball team.

Patrick’s area of greatest change was in his ability to assert himself and to consider his needs and wishes rather than passively following others in order to please them. He was able to express his fears through his play, his stories and finally through direct verbalization. A decreased need for defensiveness was evident in his posttest lie score which was also lowered by 4 points. In the final three sessions Patrick’s play and conversation was spontaneous and unencumbered by his seeking the therapist’s reassurance and approval.

For Grant, play had a cathartic value allowing him to express his intense feelings of fear, anger and aggression in a symbolic manner. His favorite toys through all sessions were the Cowboys, Indians and horses and although his play retained an aggressive quality, he was eventually able to balance this with positive interactions. Grant responded eagerly to learning relaxation exercises as a means of overcoming anxiety. He found it particularly helpful to use the breathing and muscle relaxation components when he was facing the frustration of not being able to retrieve a particular word.
The most dramatic change occurred in Grant's communication skills. As he became more comfortable in the play situation, his speech was spontaneous and relaxed and he initiated conversations with the therapist. Although Grant's Self Esteem Scores improved, he continues to set himself up for failure by placing unrealistically high expectations on himself. He continues to try to impress his peers by exaggerating his exploits and by clowning in class. Consequently he becomes more frustrated and reacts even more strongly.

**Teacher's and Parents' Post Intervention Description of The Children**

**Grant:**

According to his teacher, Grant remains fearful of social situations but is pushing himself to interact with others, e.g. he doesn't hide under his desk anymore; he greets other teachers in the hallway; he smiles more and laughs spontaneously. Grant continues with attention seeking behavior when he is called on in class and doesn't know the answers. His mother stated he is more talkative at home.

**Patrick:**

Patrick's teacher reported that he has a more positive attitude and is more cheerful in school. He demonstrates his creativity more readily in his art work and storytelling, joins in class discussions more readily, demonstrates his skill in soccer and is willing to help his
classmates learn the game. His mother added that Patrick is becoming more independent at home and has joined a soccer league.

Jimmy:
The teacher observed that the most striking changes had occurred in Jimmy. She stated that he is more willing to keep trying and to remain on task in spite of facing difficulty. He seems emotionally more mature and determined and has become the 'rock' of the class. He is stable and keeps things on an even keel.

Jimmy's parents did not report any significant changes in his behavior or attitude at home. They continued to describe him as "easygoing and lovable" and to focus on his academic deficits.

Summary
Perhaps the major implication of this study is the fact that the self-esteem of a group of learning disabled children increased by a substantial amount within a period of only twelve weeks, after exposure to social work intervention using play as the primary medium of interaction. Although both experimental and control groups demonstrated an increase in S.E.I. and B.R.P. scores, the overall amount of increase was greater for the experimental group. However a level of statistical significance to conclusively correlate the increased scores with social work intervention was not achieved. Positive behavioral and attitudinal changes that
occurred in the play sessions were observed in other aspects of the children's lives indicating the presence of some carry over.

In summary the benefits of combining a directive and non-directive intervention approach were apparent in the changes that occurred in the play process. Beginning with a non-directive approach allowed the children to experience an atmosphere that was client centered and accepting. This characterized the tone of the relationship that developed between them and the therapist. Observation of the children's choice of materials, the manner in which they approached and played with the toys, facial expressions, body posture etc. provided the therapist with information about the child's view of himself and his world. As the relationship developed, the therapist was able to become more directive as she helped the children adjust faulty perceptions, make appropriate changes and deal more productively with their environments. The children were always free to make choices. The therapist tried to convey a sense of trust, acceptance and respect for the children.

Although not statistically significant, the results suggest that intervention using play as a medium, together with a combined directive and non-directive approach, is a promising way to help learning disabled children accept and value themselves. Further research replicating this study or using a larger sample could increase confidence in the findings and allow generalization of the results.
CHAPTER V

SUMMARY AND CONCLUSION

Summary

A learning disability is a multi faceted problem that may affect a child socially and emotionally as well as academically. Many learning disabled children develop feelings of inferiority and low self-esteem. The negative labels which these children place on themselves may contribute to a self perpetuating cycle of failure. Social work intervention combining a directive and non-directive approach and using the medium of play is seen as having the potential to help learning disabled children accept and value themselves. Attitudes and expectations of teachers and family play an important role in the child's self concept. Contact with parents and teachers is recognized as an important part of working with the child. A knowledge of systems theory prepares the social worker to assume the role of co-ordinator—a role that is needed in order to avoid the hazards of confusion and fragmentation that often accompany a multi disciplinary approach. Social work intervention using the medium of play and used in conjunction with remediation is seen as a promising method of increasing the self-esteem of the learning disabled child.

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Six children from a junior level Specific Learning Disabilities Class were randomly divided into an experimental and control group. The children ranged in age from 8 to 10 years. The children met the specific admission criteria outlined by the Ontario Ministry of Education. Their disabilities were manifested mainly in the language arts (reading, spelling) and mathematics areas. One of the children in the experimental group had difficulty with expressive language and one in the control group had a social perception problem.

Because of the recognized importance of positive self-esteem, the general goal of the intervention was to increase self esteem. For each child, there were more specific individual goals. Three instruments were used in an attempt to obtain an accurate measure of self-esteem: the Coopersmith Self-Esteem Inventory, the Coopersmith Behavior Rating Form and observation of certain indicators of self esteem during intervention. Pre and post test measures of the S.E.I. and B.R.F. were obtained for both groups.

Intervention consisted of weekly 45 minute sessions with each child in the experimental group. A minimum of ten sessions were held over a period of twelve weeks. Play was used as the primary medium in the intervention. A combined directive and non-directive approach was used with the early sessions being more non-directive. As the relationship between child and therapist developed, the
therapist assumed a more directive style. Contact with the teacher and parents was maintained during the period of intervention.

The pre and post test scores obtained on the S.E.I. were compared for the experimental and control groups. A $t$ test was tone to determine the presence of an association between the increased scores of the experimental group and the intervention. Although both groups showed an increase in S.E.I. scores, the overall amount of increase was greater for the experimental group. A level of statistical significance to conclusively correlate the increased scores with social work intervention was not achieved. $t (5) = 0.839, p > .05$.

At the end of the twelve weeks, all but one of the control group children obtained increased scores on the B.R.F. Again, the overall increase was greater for the experimental group. A $t$-test was used to determine whether there was a corelation between the increased B.R.F. scores and the intervention. The obtained value indicated there was not sufficient evidence to support this hypothesis. $t (5) = 1.002, p > .05$. Pearson's $r$ was used to describe the strength and direction of association between the B.R.F. and the S.E.I. The obtained value indicated the existence of a moderate, positive relationship between the two variables. ($r = .639$) This value is in agreement with prior research that demonstrates a moderate
relationship between self-esteem and classroom behavior. (Coopersmith, 1969; Reynolds, 1980) At the end of the twelve weeks, all three children showed a decrease in the number of indicators of low-self esteem and an increase in the behavior indicating positive self-esteem.

All three experimental children demonstrated positive changes in behavior and attitude as the sessions progressed and there seemed to be some carry over into the classroom and home. One of the children is considered "at risk" for emotional maladjustment and recommendation was made for continued therapy.

Limitations of the study are recognized. The small sample size limits generalizability of the results. The question of follow up to determine the stability of the attitudinal and behavioral changes was not addressed.

**Conclusion**

The conclusion is based on the Collected data and available literature.

**Hypothesis**

Social work intervention used as a complement to remediation will increase the self-esteem of the learning disabled child.

Although the results are not statistically significant this hypothesis was partially supported by the research findings:

1) The self-esteem scores of the experimental group increased to a greater extent than did the scores of the control group.
2) The behavior rating form scores of the experimental group increased to a greater degree than those of the control group.

3) Positive indicators of self-esteem increased during intervention while negative indicators decreased.

4) Classroom behavior of the experimental group changed in areas indicating growth in self-esteem.

Self-esteem is recognized as a vital component of mental health. The way a person feels about himself influences his view of the world as well as his reaction to it. Although learning disabilities are generally defined in educational terms, it must be remembered that the disabilities influence cognitive, affective and social functioning. Learning disabled children generally have a lower level of self-esteem than do non-disabled children.

The findings of this study are in agreement with prior research indicating that learning disabled children have lower self-esteem than non-disabled children. Although self-esteem has been identified as a relatively stable variable, this study along with previous studies demonstrates that it can be altered through the concerted efforts of social worker, teacher and parents.

The children in this study lacked an understanding of the meaning of learning disabilities. They were aware of having problems learning, but they tended to blame themselves for their difficulties often labelling themselves
as "stupid" or "lazy". This observation is in agreement with the literature dealing with the topic.

Play provided a medium which encouraged the children to express their feelings and ideas and to try out different solutions to their problems. The combination of directive and non-directive techniques provided a blend of freedom and structure that encouraged the development of self acceptance but also considered the constraints of time limited intervention. This finding is in opposition to the claims of the purists who decree that one method is superior to the other in all instances. It is in agreement with those theorists who recognize the advantages of using both techniques.

Contact with parents verified the fact that parents of learning disabled children need the opportunity to express a variety of feelings and concerns about their children. Despite the open door policy of the school and the encouragement of the classroom teacher, many of the parents were hesitant about becoming more involved in their children's education.

The crucial role of the teacher in the development of the self-esteem of the early latency age child was demonstrated in this study. This observation is in agreement with prior research and literature.
Recommendations

The following recommendations developed from the findings of this study, from previous research and from the review of the literature.

**Recommendations for Future Research**

1. The need for empirical research to validate the use of play therapy as an effective form of intervention with children is evident. A beginning could be made by evaluating the various components of intervention in addition to evaluating the entire process.

2. Research needs to be done on the potential use and benefit of the various materials used in the playroom.

3. Research is needed in the area of comparing various therapy styles, i.e. directive, non-directive, combinations of the two, and in identifying the factors in the play experience that make it successful.

4. The benefit of specific techniques used for specific problem areas could be investigated, e.g. the effect of relaxation exercises in reducing anxiety.

5. There is a need for longitudinal research to assess the stability of the changes effected through intervention.

6. Replication of evaluative studies that use small samples of children would increase confidence in the findings and allow generalization of the results.
7. Research on the effect of parent involvement or non-involvement could be used to evaluate the systems approach to intervention.

Recommendations For Social Work Practice

Although the findings of this study are not conclusive, the fact that the self esteem of the experimental group of children showed movement in a positive direction suggests that social work intervention may be a valuable addition to the academic treatment of learning disabled children. The following recommendations are made based on this premise.

1. The findings of this study are in agreement with prior research which indicates the self-esteem of learning disabled children is lower than that of non-disabled children. At this time, school social workers work only with those learning disabled children who are referred, due to behavior or emotional problems. Contact with all learning disabled students either individually or with the class as a group could serve to enhance their self concepts and possibly alleviate acting out or withdrawal, as coping mechanisms. The type of contact would depend on the needs of the children as well as their stages of development. The general goals of the contact could be to help the children understand their disability, answer their questions, discuss their fears and frustrations, dispel their misconceptions and recognize their strengths.
These areas are the ones in which the children in the study seemed to experience the most difficulties. This type of involvement would incorporate the elements of treatment, prevention and enhancement.

2. The literature points out that an individual forms a general evaluation of his self worth at some time preceding latency. The preventive aspect of building positive self esteem at an early age must be considered by the school social worker. Both Windsor School Boards have an Early Identification Program which aims to identify children at risk or in need of special services at the kindergarten level. Collaboration with other agencies that are interested in child health and welfare such as Public Health and Childrens Aid Societies, could ensure that an holistic approach to treatment is provided for both child and family. The social worker's role with parents could be in the area of providing parent education - teaching parents how to recognize and deal with early symptoms of learning disabilities and helping them to understand and meet their children's emotional needs.

The benefits of increased social work involvement are in terms of enhancing the child's self-esteem as well as promoting interaction between the family and the school. The literature suggests that as families become more involved with the school and learn to better understand and deal with their learning disabled child, they will be better able to
provide an accepting environment which will further contribute to positive self-esteem.

3. The important role that teachers play in the development of their students' self-esteem is emphasized in the literature by self concept theorists and researchers. This is further demonstrated in the present study by the increased self-esteem scores of the control group. School social workers must develop in-service programs to help teachers recognize how important they are to the development of the child's self perceptions. Staff education could also focus on teaching methods of self esteem enhancement in the classroom. The positive benefits of increased self-esteem on the child's academic skills and classroom behavior are well documented in literature. This fact could be pointed out to increase teachers' interest in this area.

4. Because a learning disability is such a multifaceted condition, several disciplines are involved in the diagnosis and treatment. The literature cautions that without a skilled and knowledgeable co-ordinator, the dangers of confusion and compartmentalization exist. Social work education with its emphasis on a systems approach to problem solving prepares the school social worker to assume the role of co-ordinating agent. The social worker who is involved with the child, the family and the teacher can serve as a liason between school and home and as a co-
ordinating agent to integrate the various professional services involved in treating the child.

5. Assignment of one member of the school social work team to deal with special needs children and their families would be an effective way of providing this service. The social worker, by focusing on this area, would get a broader perspective of the problems being faced and could develop expertise in this field.

Recommendations for Education

1. The literature suggests that an integrated affective/cognitive curriculum is needed to promote optimal growth and development of the learning disabled child. Teacher education is the cornerstone upon which such a curriculum must be built. Courses dealing with the emotional requirements of special needs children must be available to every teacher since it is likely that in the future most teachers will have contact with these children either in their classrooms or in their schools.

2. The benefits of parent involvement in their child's education are documented in the literature review. The rights and responsibilities of parents of pupils with special needs are gaining attention due to increased awareness and new legislation. Despite this emphasis on parent involvement, some parents hesitate to approach teachers with their concerns for fear they will be seen as "interfering." Teachers must reach out to all parents of special needs
children, particularly to those parents who are not familiar with the workings of the educational system and who are unsure of their role within it. One method of involving parents would be to invite them into the classroom. Observation of their child in the educational milieu could provide them with a greater understanding of their child's strengths and weaknesses.

The teacher could serve as an effective model for demonstrating skills in working with the child's specific disability while the parents could share their methods of dealing with certain problems. The benefits of this involvement would be evident in both home and school.

3. Contact with parents must be recognized as an integral part of teaching children with special needs. Teacher education that includes courses in the area of working with parents together with the provision of time for consultation with parents could facilitate communication between school and home.

Recommendations for Parents

1. The crucial role that parents play in the development of their child's self-esteem is recognized throughout the literature. Parents of children with learning disabilities must accept the responsibility of becoming involved in their children's education. They must strive to increase their understanding of learning disabilities and be willing to share in the educational process.
In conclusion, although the results of this study are not statistically significant, the findings provide a basis for further research in the area of examining the role of the social worker in the treatment of children with learning disabilities.
Appendix A

Parent Consent Form For Involvement in Research Study Conducted By Graduate Social Work Student

Dear ____________

Josephine Wilds, a master’s student in Social Work at the University of Windsor has invited your son/daughter to take part in a study. The purpose of the study is to evaluate the effectiveness of social work intervention to enhance a child’s self-esteem.

The study will consist of a 58 item questionnaire to be filled by the child with the assistance of his/her teacher. The questionnaire will be administered before and after the intervention.

Four children will be randomly selected to participate in individual counselling sessions oriented toward increasing self esteem, using the medium of play. The sessions will be held on a weekly basis, over a period of twelve weeks. Regular contact with parents will be maintained.

Confidentiality is assured. Names of the children, staff or school will not be identified in the study or any subsequent reports. The study will be supervised by Dr. F.C. Hansen from the University of Windsor.

This study will be helpful in looking at the role of social work intervention in the educational system.

If you have any questions, please contact me at 254-5328. Thank you for your co-operation.

Sincerely,

Josephine Wilds.

I ____________ give permission for my son/daughter ____________ to participate in the research study conducted by Josephine Wilds, master’s student in Social Work at the University of Windsor.

Signed Parent

Date: ____________

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Appendix 3

Description of the Study Given to the Class.

The teacher will introduce the researcher to the class.

The researcher will explain that she is doing a study (project) and that the children were chosen to take part in it.

It will be emphasized that the children are playing an important part in this study and that they can offer information that may help other children learn to be happier with themselves.

They will be told that they will be asked to answer some questions about themselves and that their teacher will be there to help them. They will be reassured that it is not a test, there are no right or wrong answers and that their parents or peers will not see their answers.

The children will be told that three of them will be picked (names out of a hat) to meet with the researcher on a weekly basis for a period of twelve weeks.
Appendix C

Self-Esteem Inventory (SEI)

Please mark each statement in the following way:
If the statement describes how you usually feel, put a check ( ) in the column "Like Me".
If the statement does not describe how you usually feel, put a check ( ) in the column "Unlike Me".
There are no right or wrong answers.

1. I spend a lot of time daydreaming.     Like Me    Unlike Me
2. I'm pretty sure of myself.              Like Me    Unlike Me
3. I often wish I were someone else.      Like Me    Unlike Me
4. I'm easy to like.                       Like Me    Unlike Me
5. My parents and I have a lot of fun together.     Like Me    Unlike Me
6. I never worry about anything.           Like Me    Unlike Me
7. I find it very hard to talk in front of the class.     Like Me    Unlike Me
8. I wish I were younger.                  Like Me    Unlike Me
9. There are lots of things about myself I'd change if I could.     Like Me    Unlike Me
10. I can make up my mind without too much trouble       Like Me    Unlike Me
11. I'm a lot of fun to be with.            Like Me    Unlike Me
12. I get upset easily at home.            Like Me    Unlike Me
13. I always do the right thing.           Like Me    Unlike Me
14. I'm proud of my school work.           Like Me    Unlike Me
15. Someone always has to tell me what to do.     Like Me    Unlike Me
16. It takes me a long time to get used to anything new.     Like Me    Unlike Me
17. I'm often sorry for the things I do.    Like Me    Unlike Me
18. I'm popular with the kids my own age.   Like Me    Unlike Me
19. My parents usually consider my feelings.  
20. I'm never unhappy.  
21. I'm doing the best work that I can.  
22. I give in very easily.  
23. I can usually take care of myself.  
24. I'm pretty happy.  
25. I would rather play with children younger than me.  
26. My parents expect too much of me.  
27. I like everyone I know.  
28. I like to be called on in class.  
29. I understand myself.  
30. It's pretty tough to be me.  
31. Things are all mixed up in my life.  
32. Kids usually follow my ideas.  
33. No one pays much attention to me at home.  
34. I never get scolded.  
35. I'm not doing as well in school as I'd like to.  
36. I can make up my mind and stick to it.  
37. I really don't like being a boy/girl.  
38. I have a low opinion of myself.  
39. I don't like to be with other people.  
40. There are many times when I'd like to leave home.  
41. I'm never shy.  
42. I often feel upset in school.  
43. I often feel ashamed of myself.
44. I'm not as nice looking as most people. Like Me   Unlike Me
45. If I have something to say, I usually say it.      
46. Kids pick on me very often.       
47. My parents understand me.        
48. I always tell the truth.         
49. My teacher makes me feel I'm not good enough.    
50. I don't care what happens to me.   
51. I'm a failure.                   
52. I get upset easily when I'm scolded.       
53. Most people are better liked than I am.       
54. I usually feel as if my parents are pushing me. 
55. I always know what to say to people.         
56. I often get discouraged in school.           
57. Things usually don't bother me.             
58. I can't be depended on.                  

Note:
The following questions are lie items: 6, 13, 20, 27, 34, 41, 48, 55.
These items are included by Coopersmith to measure a defensive lie reaction.
Appendix D

Behavior Rating Form (BRF)

1. Does this child adapt easily to new situations, feel comfortable in new settings, enter easily into new activities?
   __always __usually __sometimes __seldom __never

2. Does this child hesitate to express his opinions, as evidenced by extreme caution, failure to contribute, or a subdued manner in speaking situations?
   __always __usually __sometimes __seldom __never

3. Does this child become upset by failures or other strong stresses as evidenced by such behaviors as pouting, whining, or withdrawing?
   __always __usually __sometimes __seldom __never

4. How often is this child chosen for activities by his classmates? Is his companionship sought for and valued?
   __always __usually __sometimes __seldom __never

5. Does this child become alarmed or frightened easily? Does he become very restless or jittery when procedures are changed, exams are scheduled or strange individuals are in the room?
   __always __usually __sometimes __seldom __never

6. Does this child seek much support and reassurance from his peers or the teacher, as evidenced by seeking their nearness or frequent inquiries as to whether he is doing well?
   __always __usually __sometimes __seldom __never

7. When this child is scolded or criticized, does he become either very aggressive or very sullen and withdrawn?
   __always __usually __sometimes __seldom __never

8. Does this child deprecate his school work, grades, activities, and work products? Does he indicate he is not doing as well as expected?
   __always __usually __sometimes __seldom __never
9. Does this child show confidence and assurance in his actions toward his teachers and classmates?  
___always ___usually ___sometimes ___seldom ___never

10. To what extent does this child show a sense of self esteem, self-respect, and appreciation of his own worthiness?  
___always ___usually ___sometimes ___seldom ___never

11. Does this child publicly brag or boast about his exploits?  
___always ___usually ___sometimes ___seldom ___never

12. Does this child attempt to dominate or bully other children?  
___always ___usually ___sometimes ___seldom ___never

13. Does this child continually seek attention as evidenced by such behaviors as speaking out of turn and making unnecessary noises?  
___always ___usually ___sometimes ___seldom ___never
Appendix E

Indicators of Self-Esteem Observed During Intervention

1. The child makes negative statements about self.

2. The child engages the therapist in play or conversation.

3. The child seeks the therapist's approval.
BIBLIOGRAPHY


Axline, V. "Play Therapy Procedures and Results." Symposium: Therapeutic Play Techniques, New York University, 1954.


VITA AUCTORIS

Josephine Helena Wilds was born on March 13, 1943, in Windsor, Ontario. She received her elementary and secondary school education in Windsor at St. Bernard's Elementary School and Corpus Christi High School. Following her high school graduation in 1960, she attended the Hotel Dieu Hospital School of Nursing, where she received her diploma as a Registered Nurse in 1963.

In February, 1963, she married Gord Wilds. The Wilds have four children, Renee, Michael, Robin and Stephanie.

She attended the University of Windsor and graduated in 1974, with a Bachelor of Arts degree, majoring in Psychology.

In 1975 she was employed by Hotel Dieu Hospital where she worked as a staff nurse for three years. Following this she taught Nursing at St. Clair College for three years.

In 1981 she attended the University of Windsor where she received her Bachelor of Social Work degree in May, 1982. She expects to graduate with the degree of Master of Social Work in October, 1983.

Ms. Wilds has accepted a social work position with the Essex County Children's Aid Society.